

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10549

CERTIFICATE OF DEATH

10534

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		
c. LENGTH OF STAY IN 1b <u>5 days</u>			d. STREET ADDRESS <u>Box 117, Route# 1, Laurel Md.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Michael Monroe Adams</u>			4. DATE OF DEATH <u>Oct. 22 19 56</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/55</u>	9. AGE (In years last birthday) <u>One</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None -- Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Harold G Adams</u>		
14. MOTHER'S MAIDEN NAME <u>Shibley A Worl</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Father</u> Address <u>same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia + damage</u> <u>613X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiac arrest during</u> DUE TO (c) <u>surgery for hydrocele</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>10-17 1956</u> , to <u>10-22 1956</u> , that I last saw the deceased alive on <u>10-21 1956</u> , and that death occurred at <u>2:25 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>R. F. Wilkinson</u>		M.D. <u>4408 Queensbury Rd., Riverdale, Md</u>			
PHYSICIAN'S NAME (Type) <u>R.F. Wilkinson</u>		DATE SIGNED <u>10/22/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/24/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct. 24 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> <u>Deputy</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9961 53 130 . .

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10593 **CERTIFICATE OF DEATH**

10535

Reg. Dist. No. 244

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Schineder</u> Last <u>Adell</u>				4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1956</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 26 1880</u>		9. AGE (In years last birthday) <u>75</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months _____</td> <td>Days _____ Hours _____ Min. _____</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months _____	Days _____ Hours _____ Min. _____
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months _____	Days _____ Hours _____ Min. _____												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (State or foreign country) _____		12. CITIZEN OF WHAT COUNTRY? <u>US</u>					
13. FATHER'S NAME <u>Schineder</u>				14. MOTHER'S MAIDEN NAME <u>?</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Lewis Adell</u> Address <u>Accokeek, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE-ARTERIOSCLEROTIC HEART DIS.</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>?</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour _____ a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <u>MARCH 6</u> , 19 <u>54</u> , to <u>OCT. 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>OCT. 13</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____													
ACTUAL SIGNATURE <u>Saul Zukerman</u> M.D. <u>1835 EYE ST. N.W. WASHINGTON, DC</u>				PHYSICIAN'S NAME (Type) <u>Saul Zukerman, M. D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		22d. LOCATION (City, town, or county) <u>Accokeek, Md.</u> (State) _____							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 30 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1956 OCT 30

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10537

10550

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale		c. LENGTH OF STAY IN 1b 10 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6800 Riverdale Road		d. STREET ADDRESS 6800 Riverdale Road	
3. NAME OF DECEASED (Type or print) First JOHN Middle HENJAMIN Last ALSOP		4. DATE OF DEATH Month October Day 14 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 April, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas F. Alsop		14. MOTHER'S MAIDEN NAME Mary A. Hiller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sarah E. Alsop (Wife)		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Arteriosclerosis (c) 1 day 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-7-52 , 19 50 , to 10-14 , 19 56 , that I last saw the deceased alive on 10-14-56 , 19 56 , and that death occurred at 9:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Hyattsville Md 10-15-56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/17/56	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS		ADDRESS Hyattsville, Maryland	
24. REC'D BY REGISTRAR 10-17-1956		24b. REGISTRAR'S SIGNATURE James Seaver	

CERTIFICATE OF DEATH

10658

Place of death	Home
Age	10 years
Sex	Male
Color	White
Marital status	Married
Occupation	Student
Education	High School
Religion	Catholic
Usual place of abode	Home
Usual place of birth	Home
Usual place of residence	Home

Decedent's name	John J. Smith
Decedent's date of birth	April 15, 1930
Decedent's sex	Male
Decedent's color	White
Decedent's marital status	Married
Decedent's occupation	Student
Decedent's education	High School
Decedent's religion	Catholic
Decedent's usual place of abode	Home
Decedent's usual place of birth	Home
Decedent's usual place of residence	Home

Decedent's name	John J. Smith
Decedent's date of birth	April 15, 1930
Decedent's sex	Male
Decedent's color	White
Decedent's marital status	Married
Decedent's occupation	Student
Decedent's education	High School
Decedent's religion	Catholic
Decedent's usual place of abode	Home
Decedent's usual place of birth	Home
Decedent's usual place of residence	Home

Decedent's name	John J. Smith
Decedent's date of birth	April 15, 1930
Decedent's sex	Male
Decedent's color	White
Decedent's marital status	Married
Decedent's occupation	Student
Decedent's education	High School
Decedent's religion	Catholic
Decedent's usual place of abode	Home
Decedent's usual place of birth	Home
Decedent's usual place of residence	Home

Decedent's name	John J. Smith
Decedent's date of birth	April 15, 1930
Decedent's sex	Male
Decedent's color	White
Decedent's marital status	Married
Decedent's occupation	Student
Decedent's education	High School
Decedent's religion	Catholic
Decedent's usual place of abode	Home
Decedent's usual place of birth	Home
Decedent's usual place of residence	Home

BUREAU V. 2

OCT 17 1956

RECEIVED

1 *38* *77* *J*
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
10551 1205 10-15-56L: items 10a,11,12, CERTIFICATE OF DEATH 13, 14, 16, 17, 22c. 10538										
Reg. Dist. No.										
1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Prince Georges</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg</i> <i>33</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges</i>					d. STREET ADDRESS <i>5427-TAYLOR ST</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Ella</i> <i>First</i> <i>Arbach</i> <i>Last</i>					4. DATE OF DEATH <i>OCT.</i> <i>6</i> <i>1956</i>					
5. SEX <i>FF</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 30 1892</i>		9. AGE (In years last birthday) <i>64</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>unobtainable</i>			11. BIRTHPLACE (State or foreign country) <i>Phila. Pa.</i>		
13. FATHER'S NAME <i>unobtainable</i> <i>JOHN MILLS</i>					14. MOTHER'S MAIDEN NAME <i>unobtainable</i> <i>ALICE MINOT</i> <i>Husband: Richard J. Arbach</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>					17. INFORMANT <i>Hospital records</i> <i>RUTH LANCE (5427 Taylor st.)</i>					
16. SOCIAL SECURITY NO. <i>none</i>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Infection in stump; DIABETES</i> (c) <i>Post mid thigh amputation</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Decubiti ulcers; Infected foot</i>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>31 July</i> , 19 <i>56</i> , to <i>6 Oct</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6 Oct</i> , 19 <i>56</i> , and that death occurred at <i>11:25 P.M.</i> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>John H. Bayly</i>					ADDRESS (Street, city or town, state) <i>1835 Eye N.W.</i>					
PHYSICIAN'S NAME (Type) <i>JOHN H. BAYLY</i>					DATE SIGNED <i>10/7/56</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>					22b. DATE THEREOF <i>10-7-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Magnolia</i>		22d. LOCATION (City, town, or county) (State) <i>PHILADELPHIA PA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Niles Co.</i> <i>2901 14th St N.W.</i> <i>WASHINGTON DC</i>					24a. REC'D BY REGISTRAR <i>OCT 9 '56</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>			

9561 6 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10539

10552

CERTIFICATE OF DEATH

Reg. Dist. No.

239

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>333 11th St</u>		d. STREET ADDRESS <u>333 11th St</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine E. Ayton</u>		4. DATE OF DEATH <u>October 19 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DATE OF BIRTH <u>January 1, 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
13. FATHER'S NAME <u>William H. Penn</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Galvin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Bert Ayton</u>		Address <u>333 11th St Laurel Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X RHEUMATIC HEART WITH</u> DUE TO <u>myocardial insufficiency</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Hypertension</u> DUE TO <u>Diabetes Mellitus</u> lying cause lost. <u>260X</u> (c) <u>104m</u>		INTERVAL BETWEEN ONSET AND DEATH <u>304m</u> <u>104m</u> <u>104m</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/11</u> , 19 <u>55</u> , to <u>10/19</u> , 19 <u>56</u> that I last saw the deceased alive on <u>10/18</u> , 19 <u>56</u> , and that death occurred at <u>12:40</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Warren</u>		M.D. <u>305 Prince Geo.</u>	
PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		DATE SIGNED <u>10/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Laurel</u>		22b. DATE THEREOF <u>10/21/56</u>	
22c. NAME OF CEMETERY, OR CREMATORY <u>Long Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u>		ADDRESS <u>Laurel Md</u>	
24a. REC'D BY REGISTRAR <u>1003-56</u>		24b. REGISTRAR'S SIGNATURE <u>M. Beasly</u>	

BUREAU V. 8

OCT 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10553

CERTIFICATE OF DEATH

Reg. Dist. No.

10540

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>9 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>13 S Hillside Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Baker</u>			4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>19 56</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 October 1956-</u>		9. AGE (In years last birthday) yrs. <u>9</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Baker</u>			14. MOTHER'S MAIDEN NAME <u>Willa Dean Roper</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records, Cheverly, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>flus</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1, 1956</u> , to <u>October 2, 1956</u> , that I last saw the deceased alive on <u>October 1, 1956</u> , and that death occurred at <u>1:45 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Flus Woods</u>		M.D. <u>30-C Bridge Rd, Greenbelt, Md 20756</u>		DATE SIGNED <u>Oct 2-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Macchio Sons</u>				ADDRESS <u>4137 Balto Ave Hyattsville Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 8 '56</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

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1956 8 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10594
CERTIFICATE OF DEATH

10541
130

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6821 Pineway				d. STREET ADDRESS 6821 Pineway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Helen Middle Johnson Last Bamberg				4. DATE OF DEATH Month Oct Day 22, Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 18, 1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Johnson				14. MOTHER'S MAIDEN NAME Elizabeth Sausen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Rayburn H. Bamberg, University Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Ovary</u> 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Metastases.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-10</u> , 19 <u>48</u> , to <u>10-22</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>10-20</u> , 19 <u>51</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. Deitz</u> M.D. <u>Hyattsville, Md. 10-22-51</u> PHYSICIAN'S NAME (Type) <u>Aaron Deitz, M. D.</u> <u>Hyattsville, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Entombment</u>		<u>10/24/56</u>		<u>Fort Lincoln Mausoleum</u>		<u>Colman Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasche sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>25 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10542

10595

CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 105 Rhode Island Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nannie Middle L. Last Berryman				4. DATE OF DEATH Month 10 Day 14 Year 19 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/6/33	
9. AGE (In years last birthday) 23 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Farmville, Va.	
13. FATHER'S NAME Hal Allen				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -				16. SOCIAL SECURITY NO. 579-48-0521		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculoma of pons of brain 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis DUE TO (c) -				INTERVAL BETWEEN ONSET AND DEATH 9 months 9 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/10 1956, to 10/14, 19 56, that I last saw the deceased alive on 10/13/ 19 56, and that death occurred at 5:30 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis DeCoste				ADDRESS (Street, city or town, state) DATE SIGNED 10/14/56			
PHYSICIAN'S NAME (Type) Francis DeCoste, M.D.				Glenn Dale Hospital Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE R.N. Horton				ADDRESS 1322 Georgia Street		24a. REC'D BY REGISTRAR DATE 10/14/56	
				24b. REGISTRAR'S SIGNATURE Wolfe			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10543

10554

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>6120 54th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Henry</u> Last <u>Bevans</u>				4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>19 56</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1895</u> <u>November 14, 1894</u>		9. AGE (In years, last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>60</u> Days <u>60</u> Hours <u>60</u> Min. <u>60</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Bevans</u>						14. MOTHER'S MAIDEN NAME <u>Virginia Moore</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>W.W. 1</u>				16. SOCIAL SECURITY NO. <u>W.W. 1</u>				17. INFORMANT <u>Paul F. Little; Accokeek, Md.</u> Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>442X</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.																	
ACTUAL SIGNATURE <u>John T. Maloney</u> EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>October 27, 1956</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>				22d. LOCATION (City, town, or county) (State) <u>Arlington (Va)</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Guiche sons Hyattsville, Md.</u>						24a. REC'D BY REGISTRAR <u>DATE OCT 30 '56</u>		24b. REGISTRAR'S SIGNATURE <u>Deedman</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John F. McInerney, Jr.	
Sex		Male	
Race		White	
Date of Birth		November 11, 1904	
Place of Birth		Maryland	
U.S. Navy		Gard	
Army		Arthur Hovans	
Navy		Yes	
N.A.A.		N.A.A.	
Residence		1017 E. 11th St., Baltimore, Md.	
Cause of Death		Is the congestive heart failure	
Contributing Cause		Arteriosclerotic renal disease	
Signature of Physician		John F. McInerney, Jr.	
Signature of Medical Examiner		[Signature]	

BUREAU V. S.

OCT 30 1956

RECEIVED

John F. McInerney, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10544

Reg. Dist. No.

10555

1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) ✓ a. STATE Washington D. C. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly Md		c. LENGTH OF STAY IN 1b 10 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 77 Prince George's General Hospital				d. STREET ADDRESS 1318 Massachusetts Ave, N. W.			
3. NAME OF DECEASED (Type or print) First Middle Last Emory Oley Bowen				4. DATE OF DEATH Month Day Year October 20, 19 56.			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Dec 18, 1877		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Stanley Horner Co. Automobile				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Elijah Bowen			
14. MOTHER'S MAIDEN NAME Mollie King				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no			
16. SOCIAL SECURITY NO. 577-10-5841				17. INFORMANT Edward L. Bowen			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 442x PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-21-56.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/56		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery			
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stansbury				ADDRESS 6411 Windsor Mill Rd. 7			
24a. REC'D BY REGISTRAR DATE 24 '56				24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. McNamee	
Sex		Male	
Age		35	
Date of Birth		1920	
Place of Birth		Maryland	
Usual Residence		1316 Pennsylvania Ave., N.W., Wash., D.C.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Death		October 24, 1956	

BUREAU V. 2

OCT 24 1956

RECEIVED

10556

CERTIFICATE OF DEATH

10545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Hannover</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>Gorman Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Brown</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-72</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u>54</u> Days <u>16</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pr. Geo. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Ann Barnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Hubert Brown, Laurel Md.</u>		Address <u>Laurel Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>48 hrs</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/14</u> , 19 <u>56</u> , to <u>10/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/16</u> , 19 <u>56</u> , and that death occurred at <u>5</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Pennys St</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>		DATE SIGNED <u>10/16/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Witt Donaldson</u>		ADDRESS <u>Laurel, Md.</u>	
24a. REC'D BY REGISTRAR <u>10/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>Al Houch</u>	

CERTIFICATE OF DEATH

100-50

1. PLACE OF DEATH HOME		2. HUSBAND JAMES H. HARRIS	
3. CITY OR TOWN BALTIMORE		4. COUNTY BALTIMORE	
5. STATE MARYLAND		6. ZIP CODE 21201	
7. DATE OF DEATH OCTOBER 22, 1956		8. TIME OF DEATH 10:30 AM	
9. SEX MALE		10. AGE 68	
11. OCCUPATION RETIRED		12. CAUSE OF DEATH HEART DISEASE	
13. MANNER OF DEATH NATURAL		14. PLACE OF BIRTH BALTIMORE	
15. DATE OF BIRTH JANUARY 1, 1888		16. PLACE OF DEATH HOME	
17. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		18. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
19. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		20. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
21. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		22. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
23. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		24. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
25. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		26. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
27. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		28. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
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31. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		32. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
33. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		34. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
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41. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		42. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
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49. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		50. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
51. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		52. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
53. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		54. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
55. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		56. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
57. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		58. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
59. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		60. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
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67. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		68. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
69. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		70. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
71. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		72. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
73. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		74. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
75. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		76. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
77. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		78. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
79. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		80. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
81. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		82. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
83. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		84. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
85. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		86. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
87. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		88. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
89. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		90. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
91. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		92. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
93. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		94. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
95. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		96. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
97. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		98. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	
99. NAME OF DEATH CERTIFICATE JAMES H. HARRIS		100. NAME OF DEATH CERTIFICATE JAMES H. HARRIS	

BUREAU V. 3

OCT 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10546

10557

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly				c. LENGTH OF STAY IN 1b Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hsopital				d. STREET ADDRESS 5709--64th Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First REMUS Middle E Last BROWN				4. DATE OF DEATH Month October Day 7th Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1898		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Adjuster		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop Dept.		11. BIRTHPLACE (State or foreign country) Monroe County, Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie Brown				14. MOTHER'S MAIDEN NAME Lizzie Goggins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 255-18-8327		17. INFORMANT Marie V. Brown Address 5709--64th Ave. Riverdale Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic cardio vascular disease DUE TO (c) years						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March , 19 56 , to October 7 , 19 56 , that I last saw the deceased alive on October 7 , 19 56 , and that death occurred at 4:30 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald S Freischer M.D.				ADDRESS (Street, city or town, state) 5432 Queens Chapel Rd Hyattsville Md			
PHYSICIAN'S NAME (Type) RONALD S FREISCHER				DATE SIGNED 10/8/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9/1956		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR Oct 15 56		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

9561 21 100

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10547

Reg. Dist. No. 245

10555

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS Laurel	
3. NAME OF DECEASED (Type or print) First Lester Middle Marion Last Browning		4. DATE OF DEATH Month 10 - Day 7 - Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-18-98
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labarier		10b. KIND OF BUSINESS OR INDUSTRY add jobs	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace McCauley Browning		14. MOTHER'S MAIDEN NAME Margaret Ollie Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO 900.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fall DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from steps hitting his head on steps or sidewalk.	
20c. TIME OF INJURY Month, Day, Year 6.00 Hour 10-2-56 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Laurel Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-2-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Randall		ADDRESS Laurel Md	
24a. REC'D BY REGISTRAR Oct 11 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Bevere	

STATE OF MARYLAND
DEPARTMENT OF HEALTH - PUBLIC HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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500-15-1 2/4

32-301

BUREAU V. S.

15 OCT 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.																																																																																																																											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights																																																																																																																										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 603 62nd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																																																																									
3. NAME OF DECEASED (Type or print) First Paul Middle Ellington Last Cash				4. DATE OF DEATH Month October Day 23 , Year 19 56																																																																																																																											
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-18-10																																																																																																																									
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer																																																																																																																									
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.																																																																																																																									
13. FATHER'S NAME William Hadley Cash				14. MOTHER'S MAIDEN NAME Catherine Butler																																																																																																																											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Annadale Sykes; 607- 62nd Ave., Fairmount Hts.																																																																																																																											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4" style="vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure </td> <td colspan="4" rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> DUE TO </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> Cardiovascular renal disease </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> Conditions, if any, which gave rise to immediate cause (b) </td> <td colspan="4" rowspan="2" style="vertical-align: top;"> </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> (c) DUE TO </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) </td> <td colspan="4" rowspan="2" style="vertical-align: top;"> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. </td> <td colspan="4" style="vertical-align: top;"> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> 20c. TIME OF INJURY Hour o. m. p. m. </td> <td colspan="2" style="vertical-align: top;"> Month, Day, Year 19 </td> <td colspan="2" style="vertical-align: top;"> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> </td> <td colspan="2" style="vertical-align: top;"> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> 20f. (City or town) </td> <td colspan="2" style="vertical-align: top;"> (County) </td> <td colspan="2" style="vertical-align: top;"> (State) </td> <td colspan="2" style="vertical-align: top;"> </td> </tr> <tr> <td colspan="8" style="vertical-align: top;"> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> ACTUAL SIGNATURE John T. Maloney </td> <td colspan="4" style="vertical-align: top;"> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> EXAMINER'S NAME (Type) John T. Maloney, M.D. </td> <td colspan="4" style="vertical-align: top;"> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> </td> <td colspan="4" style="vertical-align: top;"> DATE SIGNED October 23, 1956 </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial </td> <td colspan="2" style="vertical-align: top;"> 22b. DATE THEREOF 10/27/56 </td> <td colspan="2" style="vertical-align: top;"> 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery </td> <td colspan="2" style="vertical-align: top;"> 22d. LOCATION (City, town, or county) (State) Washington, D.C. </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> 23. FUNERAL DIRECTOR'S SIGNATURE John T. Maloney </td> <td colspan="2" style="vertical-align: top;"> ADDRESS 30 H Street, N.E. </td> <td colspan="2" style="vertical-align: top;"> 24a. REC'D BY REGISTRAR DATE 10 25 56 </td> </tr> <tr> <td colspan="4" style="vertical-align: top;"> </td> <td colspan="2" style="vertical-align: top;"> 24b. REGISTRAR'S SIGNATURE Oneil </td> <td colspan="2" style="vertical-align: top;"> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure				INTERVAL BETWEEN ONSET AND DEATH				DUE TO				Cardiovascular renal disease				Conditions, if any, which gave rise to immediate cause (b)								(c) DUE TO				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED October 23, 1956				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.		23. FUNERAL DIRECTOR'S SIGNATURE John T. Maloney				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR DATE 10 25 56						24b. REGISTRAR'S SIGNATURE Oneil			
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 LIFE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Annabelle Sykes; 507- 62nd Ave., Baltimore, Md.		Female		7-1-19		October 22, 1956	
Place of Death		Cause of Death		Manner of Death		Occupation	
Home		Acute congestive heart failure		Natural		Housewife	
Physician		Hospital		Burial		Funeral Home	
Dr. William H. Hoffer		St. Joseph's Hospital		St. Joseph's Cemetery		St. Joseph's Funeral Home	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 5

OCT 25 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10549
245

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rinendale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hospital</u>		d. STREET ADDRESS <u>All Saints Road. Route #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Stacy</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-09</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Randolph Brown</u>		14. MOTHER'S MAIDEN NAME <u>Ida Genera Ball</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Record.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO <u>Hypertensive Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 5 1956</u> to <u>Oct 8 1956</u> , that I last saw the deceased alive on <u>Oct 8 1956</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D.		DATE SIGNED <u>Oct 8 1956</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C WINGFIELD</u>			
22a. BURIAL CREMATION <u>Burial</u> 22b. DATE THEREOF <u>Oct 10 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Md (P.G. County)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neil B. Donaldson</u> ADDRESS <u>Laurel Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page Two

1. NAME OF DECEASED <i>John William Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>October 15, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. EDUCATION <i>High School</i>		12. MARITAL STATUS <i>Married</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John William Smith</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John William Smith</i>	
19. SIGNATURE OF DECEASED <i>John William Smith</i>		20. SIGNATURE OF DECEASED <i>John William Smith</i>		21. SIGNATURE OF DECEASED <i>John William Smith</i>	
22. SIGNATURE OF DECEASED <i>John William Smith</i>		23. SIGNATURE OF DECEASED <i>John William Smith</i>		24. SIGNATURE OF DECEASED <i>John William Smith</i>	
25. SIGNATURE OF DECEASED <i>John William Smith</i>		26. SIGNATURE OF DECEASED <i>John William Smith</i>		27. SIGNATURE OF DECEASED <i>John William Smith</i>	
28. SIGNATURE OF DECEASED <i>John William Smith</i>		29. SIGNATURE OF DECEASED <i>John William Smith</i>		30. SIGNATURE OF DECEASED <i>John William Smith</i>	
31. SIGNATURE OF DECEASED <i>John William Smith</i>		32. SIGNATURE OF DECEASED <i>John William Smith</i>		33. SIGNATURE OF DECEASED <i>John William Smith</i>	
34. SIGNATURE OF DECEASED <i>John William Smith</i>		35. SIGNATURE OF DECEASED <i>John William Smith</i>		36. SIGNATURE OF DECEASED <i>John William Smith</i>	
37. SIGNATURE OF DECEASED <i>John William Smith</i>		38. SIGNATURE OF DECEASED <i>John William Smith</i>		39. SIGNATURE OF DECEASED <i>John William Smith</i>	
40. SIGNATURE OF DECEASED <i>John William Smith</i>		41. SIGNATURE OF DECEASED <i>John William Smith</i>		42. SIGNATURE OF DECEASED <i>John William Smith</i>	
43. SIGNATURE OF DECEASED <i>John William Smith</i>		44. SIGNATURE OF DECEASED <i>John William Smith</i>		45. SIGNATURE OF DECEASED <i>John William Smith</i>	
46. SIGNATURE OF DECEASED <i>John William Smith</i>		47. SIGNATURE OF DECEASED <i>John William Smith</i>		48. SIGNATURE OF DECEASED <i>John William Smith</i>	
49. SIGNATURE OF DECEASED <i>John William Smith</i>		50. SIGNATURE OF DECEASED <i>John William Smith</i>		51. SIGNATURE OF DECEASED <i>John William Smith</i>	
52. SIGNATURE OF DECEASED <i>John William Smith</i>		53. SIGNATURE OF DECEASED <i>John William Smith</i>		54. SIGNATURE OF DECEASED <i>John William Smith</i>	
55. SIGNATURE OF DECEASED <i>John William Smith</i>		56. SIGNATURE OF DECEASED <i>John William Smith</i>		57. SIGNATURE OF DECEASED <i>John William Smith</i>	
58. SIGNATURE OF DECEASED <i>John William Smith</i>		59. SIGNATURE OF DECEASED <i>John William Smith</i>		60. SIGNATURE OF DECEASED <i>John William Smith</i>	
61. SIGNATURE OF DECEASED <i>John William Smith</i>		62. SIGNATURE OF DECEASED <i>John William Smith</i>		63. SIGNATURE OF DECEASED <i>John William Smith</i>	
64. SIGNATURE OF DECEASED <i>John William Smith</i>		65. SIGNATURE OF DECEASED <i>John William Smith</i>		66. SIGNATURE OF DECEASED <i>John William Smith</i>	
67. SIGNATURE OF DECEASED <i>John William Smith</i>		68. SIGNATURE OF DECEASED <i>John William Smith</i>		69. SIGNATURE OF DECEASED <i>John William Smith</i>	
70. SIGNATURE OF DECEASED <i>John William Smith</i>		71. SIGNATURE OF DECEASED <i>John William Smith</i>		72. SIGNATURE OF DECEASED <i>John William Smith</i>	
73. SIGNATURE OF DECEASED <i>John William Smith</i>		74. SIGNATURE OF DECEASED <i>John William Smith</i>		75. SIGNATURE OF DECEASED <i>John William Smith</i>	
76. SIGNATURE OF DECEASED <i>John William Smith</i>		77. SIGNATURE OF DECEASED <i>John William Smith</i>		78. SIGNATURE OF DECEASED <i>John William Smith</i>	
79. SIGNATURE OF DECEASED <i>John William Smith</i>		80. SIGNATURE OF DECEASED <i>John William Smith</i>		81. SIGNATURE OF DECEASED <i>John William Smith</i>	
82. SIGNATURE OF DECEASED <i>John William Smith</i>		83. SIGNATURE OF DECEASED <i>John William Smith</i>		84. SIGNATURE OF DECEASED <i>John William Smith</i>	
85. SIGNATURE OF DECEASED <i>John William Smith</i>		86. SIGNATURE OF DECEASED <i>John William Smith</i>		87. SIGNATURE OF DECEASED <i>John William Smith</i>	
88. SIGNATURE OF DECEASED <i>John William Smith</i>		89. SIGNATURE OF DECEASED <i>John William Smith</i>		90. SIGNATURE OF DECEASED <i>John William Smith</i>	
91. SIGNATURE OF DECEASED <i>John William Smith</i>		92. SIGNATURE OF DECEASED <i>John William Smith</i>		93. SIGNATURE OF DECEASED <i>John William Smith</i>	
94. SIGNATURE OF DECEASED <i>John William Smith</i>		95. SIGNATURE OF DECEASED <i>John William Smith</i>		96. SIGNATURE OF DECEASED <i>John William Smith</i>	
97. SIGNATURE OF DECEASED <i>John William Smith</i>		98. SIGNATURE OF DECEASED <i>John William Smith</i>		99. SIGNATURE OF DECEASED <i>John William Smith</i>	
100. SIGNATURE OF DECEASED <i>John William Smith</i>		101. SIGNATURE OF DECEASED <i>John William Smith</i>		102. SIGNATURE OF DECEASED <i>John William Smith</i>	

RECEIVED
OCT 15 1956
BUREAU V. 3

10596

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Fairmont Hgts		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Hgts	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS 906 59th Ave	
3. NAME OF DECEASED (Type or print) First MARY Middle Coleman Last		4. DATE OF DEATH Month Oct Day 3 Year 1956	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 7-1898
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Charlottesville Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William White		14. MOTHER'S MARDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Isaac Coleman		Address 906 59th Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension (c) Essential Hypertension			INTERVAL BETWEEN ONSET AND DEATH 3 days 3 mo. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIO-VASCULAR Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1955, to Oct 30, 1956, that I last saw the deceased alive on Oct 30, 1956, and that death occurred at 8:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert R. Nelson		ADDRESS (Street, city or town, state) 4112 GRANT ST. NE	
PHYSICIAN'S NAME (Type) Robert R. Nelson		DATE SIGNED 10/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-6-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Burrington Rd SE N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		ADDRESS 467 N 2nd St	
24a. REC'D BY REGISTRAR DATE Oct. 9, 1956		24b. REGISTRAR'S SIGNATURE Carrie F. Campbell	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

OCT 11 1956

RECEIVED

10597

CERTIFICATE OF DEATH

Reg. Dist. No.

24r

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Brandywine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Brandywine</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Schrader Cress</u>				4. DATE OF DEATH Month Day Year <u>Oct. 17 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 2nd 1885</u>	9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Dawa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Schrader</u>				14. MOTHER'S MAIDEN NAME <u>Whilomenia Faulk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Mrs Maxine Cress Bond</u>				Address <u>Brandywine, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ingested Infantine</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Alterschismus</u> DUE TO (c) <u>aging</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>yes</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10-1</u> , 19 <u>56</u> , to <u>10-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-17</u> , 19 <u>56</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.				ADDRESS (Street, city or town, state) <u>Brandywine, Md.</u> DATE SIGNED <u>10/17/56</u>			
PHYSICIAN'S NAME (Type) <u>Rich &rd H. Dobson</u>				ADDRESS <u>Brandywine, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cederville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cedarville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>				24. REC'D BY REGISTRAR <u>22 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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217

OCT 22 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10598

CERTIFICATE OF DEATH

10552

Reg. Dist. No. 230

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>SAME</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MURKIRK</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MURKIRK Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSSVILLE RD</u>				d. STREET ADDRESS <u>ROSSVILLE Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>—</u> Last <u>CRUMP</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25, 1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE ROAD COMMISSION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ISRAEL CRUMP</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH WHALE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ADELINE COLEMAN—MURKIRK MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JANUARY, 1954</u> , to <u>OCTOBER 24, 1956</u> , that I last saw the deceased alive on <u>OCTOBER 23, 1956</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city, or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John R. Buell</u> M.D. <u>402 Main St. Laurel Md. 10/24/56</u> PHYSICIAN'S NAME (Type) <u>John R. BUELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-27-56</u>		22b. DATE THEREOF <u>10-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Queens Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Murkirk Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS <u>467 N st. N.W</u>				24a. REC'D BY REGISTRAR DATE <u>10-26-1956</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10554

Reg. Dist. No.

10599

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale			c. LENGTH OF STAY IN lb transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Road				d. STREET ADDRESS 3708 Allison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Edward Last Day				4. DATE OF DEATH Month 10 Day 20 Year 19 56			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-29		9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Engineering resrarch		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wallace Eugene Day				14. MOTHER'S MAIDEN NAME Mary Elizabeth King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes 1950-53 Army		16. SOCIAL SECURITY NO. 577-34-1851		17. INFORMANT Cornelia Williams; 4004 36th Street, Mt. Rainier			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound, comminuted fracture of skull DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pinned under overturned automobile. No 2nd car involved.					
20c. TIME OF INJURY Month, Day, Year 5.25 Oct. 20, 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Glenn Dale Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 20, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/56		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Wheaton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR OCT 23 1956	
				24b. REGISTRAR'S SIGNATURE <i>Dr. Mac Hess</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10544

CERTIFICATE OF DEATH

10555

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 3 yrs. 3mons.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescent 5801--42nd Avenue				d. STREET ADDRESS 6302--47th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES EDWARD DINTAMAN				4. DATE OF DEATH Month Day Year October 23rd, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8th, 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpet layer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Carpet Ind.		11. BIRTHPLACE (State or foreign country) Greensburg, Ind.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Gertrude S. Curtis, 4507--38th Street, Brentwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 1977x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 15, 1953, to 10/23, 1956, that I last saw the deceased alive on 10/20, 1956, and that death occurred at 8:00 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE F. E. Musser				M.D. 7409 VARNUM ST ADDRESS (Street, city or town, state) Landover Hills, Md.			
DATE SIGNED 10/23/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 25/1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 10/26/56	
				24b. REGISTRAR'S SIGNATURE James C. Sever			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10561

CERTIFICATE OF DEATH

Reg. Dist. No.

10556

1. PLACE OF DEATH a. COUNTY Prince Georges! MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges! General Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Emma Middle V. Last Drury		4. DATE OF DEATH Month 10 Day 20 Year 1956.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1876
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James R. Drury		14. MOTHER'S MAIDEN NAME Jane Ida Bassford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT George R. Drury		Address Drury, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 1442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Cardio - Renal DUE TO (c) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1956 to Oct 20, 1956 , that I last saw the deceased alive on Oct. 20, 1956 , and that death occurred at 9:50 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland. DATE SIGNED 10-21-56			
ACTUAL SIGNATURE James G. Sasseer M.D.			
PHYSICIAN'S NAME (Type) James G. Sasseer.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Lothian Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE OCT 25 '56	
		24b. REGISTRAR'S SIGNATURE W. H. Smith	

BUREAU A. S.

OCT 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10557

10600

CERTIFICATE OF DEATH

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE Penna. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Duquesne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Sachem Drive		d. STREET ADDRESS 209 S. First St.	
3. NAME OF DECEASED (Type or print) Joseph John Dudas		4. DATE OF DEATH October 26 19 56	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/25/1879	
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Steel Industry, Carnegie		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Dudas		14. MOTHER'S MAIDEN NAME Mary Saxon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. J.P. Kiavetz		Address Forest Hts, Md. 211 Sachem Drive,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of stomach with metastases to liver 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 6, 1956 , to Oct. 26, 1956 , that I last saw the deceased alive on October 19, 1956 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Sacks M.D.		ADDRESS (Street, city or town, state) 3036 M Place, S.E. Wash, D.C.	
PHYSICIAN'S NAME (Type) Harry Sacks, M.D.		DATE SIGNED 10/26/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 10/26/56		22b. DATE THEREOF 10/26/56	
22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cem.		22d. LOCATION (City, town, or county) (State) Duquesne, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., Wash, DC		24a. REC'D BY REGISTRAR Oct 29 1956	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

CERTIFICATE OF DEATH

First Name George		Last Name Jones	
Sex Male		Race White	
Date of Birth 1900		Place of Birth Baltimore, Md.	
Date of Death 1950		Place of Death Baltimore, Md.	
Cause of Death Heart Disease		Manner of Death Natural	
Doctor's Name Dr. J. H. Jones		Hospital Name St. Joseph's Hospital	
Signature of Doctor J. H. Jones		Signature of Registrar J. H. Jones	

BUREAU V. S.

Oct 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10601

CERTIFICATE OF DEATH

Reg. Dist. No.

10558

242

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5447 Silver Hill Rd. S.E.</u>				d. STREET ADDRESS <u>5447 Silver Hill Rd. S.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW M DUSTIN</u>				4. DATE OF DEATH Month Day Year <u>10-12-1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S.C. Goeth.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BRIZZILLA DUSTIN</u>				14. MOTHER'S MAIDEN NAME <u>MARY MERCER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-28-9285</u>		17. INFORMANT Address <u>MARION DUSTIN PARKLAND MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>— none —</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>56</u> , to <u>Oct 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 11</u> , 19 <u>56</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul C VanNatta</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>5440 Silver Hill Rd SE Washington 28 DC</u>			
PHYSICIAN'S NAME (Type) <u>PAUL C VANNATTA</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-15-56</u>		<u>CEDAR HILL</u>		<u>SUITLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.W. Chambers Co 517-11 SE</u>				24a. REC'D BY REGISTRAR DATE <u>Oct 15 56</u>		24b. REGISTRAR'S SIGNATURE <u>Edna F. Collins</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>10-15-1925</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
MIDDLE NAME <i>Robert</i>		DATE OF DEATH <i>10-22-1956</i>		PLACE OF DEATH <i>St. Louis, Mo.</i>	
SEX <i>Male</i>		AGE <i>31</i>		OCCUPATION <i>Student</i>	
MARRIAGE <i>Never</i>		EDUCATION <i>High School</i>		RELIGION <i>Catholic</i>	
MOTHER'S NAME <i>John Doe</i>		FATHER'S NAME <i>John Doe</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MOTHER'S MAIDEN NAME <i>John Doe</i>		FATHER'S MAIDEN NAME <i>John Doe</i>		MANNER OF DEATH <i>Natural</i>	
MOTHER'S BIRTH <i>10-15-1925</i>		FATHER'S BIRTH <i>10-15-1925</i>		DATE OF BURIAL <i>10-23-1956</i>	
MOTHER'S PLACE OF BIRTH <i>St. Louis, Mo.</i>		FATHER'S PLACE OF BIRTH <i>St. Louis, Mo.</i>		PLACE OF BURIAL <i>St. Louis, Mo.</i>	
MOTHER'S OCCUPATION <i>Student</i>		FATHER'S OCCUPATION <i>Student</i>		DATE OF INTERMENT <i>10-23-1956</i>	
MOTHER'S MARRIAGE <i>Never</i>		FATHER'S MARRIAGE <i>Never</i>		PLACE OF INTERMENT <i>St. Louis, Mo.</i>	
MOTHER'S EDUCATION <i>High School</i>		FATHER'S EDUCATION <i>High School</i>		DATE OF CREMATION <i>10-23-1956</i>	
MOTHER'S RELIGION <i>Catholic</i>		FATHER'S RELIGION <i>Catholic</i>		PLACE OF CREMATION <i>St. Louis, Mo.</i>	
MOTHER'S DEATH <i>10-15-1925</i>		FATHER'S DEATH <i>10-15-1925</i>		DATE OF EXHUMATION <i>10-23-1956</i>	
MOTHER'S PLACE OF DEATH <i>St. Louis, Mo.</i>		FATHER'S PLACE OF DEATH <i>St. Louis, Mo.</i>		PLACE OF EXHUMATION <i>St. Louis, Mo.</i>	
MOTHER'S OCCUPATION <i>Student</i>		FATHER'S OCCUPATION <i>Student</i>		DATE OF REINTERMENT <i>10-23-1956</i>	
MOTHER'S MARRIAGE <i>Never</i>		FATHER'S MARRIAGE <i>Never</i>		PLACE OF REINTERMENT <i>St. Louis, Mo.</i>	
MOTHER'S EDUCATION <i>High School</i>		FATHER'S EDUCATION <i>High School</i>		DATE OF RECREMATION <i>10-23-1956</i>	
MOTHER'S RELIGION <i>Catholic</i>		FATHER'S RELIGION <i>Catholic</i>		PLACE OF RECREMATION <i>St. Louis, Mo.</i>	

BUREAU V. 3

OCT 22 1956

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10602

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY in 1b 1 mo., & 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1424 L. St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leonard W. Easter			4. DATE OF DEATH Month 10 Day 21 Year 19 56				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/13		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optician		10b. KIND OF BUSINESS OR INDUSTRY Sterling Opticians		11. BIRTHPLACE (State or foreign country) Patric, VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Henry Easter				14. MOTHER'S MAIDEN NAME Sally Willie Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 223-05-1740		17. INFORMANT Decedent Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162x Bronchogenic carcinoma, left lung, with metastasis cerebral 3 months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5, 19 56, to 10/21, 19 56, that I last saw the deceased alive on 10/21, 19 56, and that death occurred at 10:45AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Daniel Leo Finucane M.D. Glenn Dale Hospital 10/21/56 PHYSICIAN'S NAME (Type) Daniel Leo Finucane, M. D. Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. B. H. Hines Co 3901-14th St. N.W.				42a. REC'D BY REGISTRAR DATE 10/21/56		24b. REGISTRAR'S SIGNATURE Miss	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10560

Reg. Dist. No.

239

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 23 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 North 2nd. Street			d. STREET ADDRESS 2 North 2nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Ellis			4. DATE OF DEATH Month October Day 10 Year 1956		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1888		9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Quartermaster		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Gunn		11. BIRTHPLACE (State or foreign country) Laurel, Md.	
13. FATHER'S NAME Lawrence Ellis			14. MOTHER'S MAIDEN NAME Sarah Gurley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Oct. 10, 1956
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/13/56		22c. NAME OF CEMETERY OR CREMATORY Carmen Menz Park	
				22d. LOCATION (City, town, or county) (State) Thurmont, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donahoe			ADDRESS Laurel, Md.		24a. REC'D BY REGISTRAR DATE Oct 16 56
					24b. REGISTRAR'S SIGNATURE M. Broshear

MEDICAL CERTIFICATION

RECEIVED

OCT 18 1956

BUREAU V. E.

10563

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College PK.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>				d. STREET ADDRESS <u>4612 Amhurst Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna P. FABER</u>				4. DATE OF DEATH <u>Oct. 3 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-79</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Harry Parker</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Record</u> Address <u>Cheverly, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Bladder, early</u> <u>181X</u> DUE TO <u>metastasis to rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-3</u> , 19 <u>54</u> to <u>10-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-3</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.				ADDRESS (Street, city or town, state) <u>4713-Bromley Rd</u>		DATE SIGNED <u>10/3/56</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>				<u>College Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>OCT 8 '56</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Etienne</u>	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81

1956 8 OCT

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and if any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10562

10603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Coral Hills</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Coral Hills</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1510-52nd Ave</i>				d. STREET ADDRESS <i>1510-52nd Ave</i>			
3. NAME OF DECEASED (Type or print) <i>IDA SYLVANIA FAWTHORP</i>				4. DATE OF DEATH Month <i>October</i> Day <i>29</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 9, 1884</i>	9. AGE (In years last birthday) <i>72</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Smith</i>				14. MOTHER'S MAIDEN NAME <i>May Ann Wharton</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Marion E McKnett</i>		Address <i>Coral Hills 1510-52nd Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Vascular Renal Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1, 1956</i> to <i>Oct 29, 1956</i> that I last saw the deceased alive on <i>Oct 28, 1956</i> , and that death occurred at <i>9:45 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William Brainin</i> M.D.				ADDRESS (Street, city or town, state) <i>6124 Central Ave</i>		DATE SIGNED <i>10/29/56</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM BRAININ</i>				<i>Capital Hotel Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-1-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>SUNSET MEM PARK</i>		22d. LOCATION (City, town, or county) (State) <i>PHILADELPHIA PA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DEAL FUNERAL HOME</i>				ADDRESS <i>4812 24 Ave NW</i>		24a. REC'D BY REGISTRAR <i>Nov 1 '56</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>			

CERTIFICATE OF DEATH

Form 10-1-34

<p>1. Name of deceased: <i>William B. B. B.</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>12-10-1870</i></p>		<p>4. Age: <i>63 years</i></p>	
<p>5. Place of birth: <i>England</i></p>		<p>6. Date of death: <i>Nov 1 1936</i></p>	
<p>7. Cause of death: <i>Heart failure</i></p>		<p>8. Immediate cause: <i>Myocardial infarction</i></p>	
<p>9. Duration of illness: <i>2 weeks</i></p>		<p>10. Place of death: <i>Home</i></p>	
<p>11. Name of physician: <i>Dr. J. H. H.</i></p>		<p>12. Name of funeral director: <i>W. B. B.</i></p>	
<p>13. Name of informant: <i>W. B. B.</i></p>		<p>14. Address of informant: <i>1234 St. St.</i></p>	
<p>15. Signature of physician: <i>J. H. H.</i></p>		<p>16. Signature of informant: <i>W. B. B.</i></p>	

BUREAU V. B.

NOV 1 1936

RECEIVED

10604

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntsville</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In a wooded area</u>				d. STREET ADDRESS <u>5092 Just Street</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Alonso</u> Last <u>Felder</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 6, 1916</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>		11. BIRTH PLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Felder</u>				14. MOTHER'S MAIDEN NAME <u>Irene Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW 11</u>		17. INFORMANT <u>Engelader Felder</u> Address <u>5068 Just St Washington DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute Carbon monoxide poisoning</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran home from exhaust into car and let motor run</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>6:43 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) (County) (State) <u>Huntsville P. G. Ma</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Oct 31, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-6-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MALVAN & SCHEY, INC. 424 "R" St., N. W.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 8 '56</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text]
2. SEX: [Faint text]
3. AGE: [Faint text]
4. OCCUPATION: [Faint text]
5. PLACE OF BIRTH: [Faint text]
6. DATE OF DEATH: [Faint text]
7. TIME OF DEATH: [Faint text]
8. CAUSE OF DEATH: [Faint text]
9. MANNER OF DEATH: [Faint text]
10. SIGNATURE OF EXAMINER: [Faint text]
11. SIGNATURE OF WITNESS: [Faint text]
12. SIGNATURE OF CORONER: [Faint text]

BUREAU V. S.

NOV 8 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10605 CERTIFICATE OF DEATH

10564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
c. LENGTH OF STAY IN TB 3 yrs		d. STREET ADDRESS 6317 Field St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6317 Field St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle D Last FOOSE		4. DATE OF DEATH Month October Day 30 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 1, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pawnee Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Charles Dost		14. MOTHER'S MAIDEN NAME Ada Pattysen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr Lucille Kinkade, daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Heart Disease (c) Disease INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 15, 1953 , to Oct 30, 1956 , that I last saw the deceased alive on Oct 30, 1956 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin		ADDRESS (Street, city or town, state) 6124 Central Ave	
PHYSICIAN'S NAME (Type) WM. BRAININ		DATE SIGNED 11/20/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 2, 1956	
22c. NAME OF CEMETERY OR CREMATORY Pawnee City Cem.		22d. LOCATION (City, town, or county) (State) Pawnee, Nebraska	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co, Washington, D.C.		24. REGISTRAR'S SIGNATURE Carrie Campbell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10564

CERTIFICATE OF DEATH

10565

Items 7, 8 Film 206 11-8-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>806 Colby Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Llewyn</u> Middle <u>Ford</u> Last <u>Ford</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Claude Ford</u>		Address <u>806 Colby Ave Takoma Park, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-10-1956</u> , to <u>10-15-1956</u> , that I last saw the deceased alive on <u>10-15-1956</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Moore</u> M.D.		ADDRESS (Street, city or town, state) <u>Reveree</u> DATE SIGNED <u>10-16-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-19-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Snodgrass</u> ADDRESS <u>Rockville</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 23 '56</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>

MEDICAL CERTIFICATION

1

38

77

CERTIFICATE OF DEATH

Page No. 10

1. Name of deceased <i>Mr. John A. Smith</i>		2. Sex <i>Male</i>	
3. Date of birth <i>Jan. 12, 1916</i>		4. Age <i>39</i>	
5. Date of death <i>Jan. 18, 1956</i>		6. Time of death <i>10:15 P.M.</i>	
7. Place of death <i>Home</i>		8. Cause of death <i>Heart disease</i>	
9. Immediate cause of death <i>Myocardial infarction</i>		10. Underlying cause of death <i>Coronary artery disease</i>	
11. Manner of death <i>Natural</i>		12. Signature of physician <i>[Signature]</i>	
13. Signature of registrar <i>[Signature]</i>		14. Date of registration <i>Jan. 23, 1956</i>	

BUREAU V. 3

OCT 23 1956

RECEIVED

Handwritten notes and signatures at the bottom of the form.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 208 12-28-56 ans

10565

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntsville, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 7301 Sheriff Road.	
3. NAME OF DECEASED (Type or print) First Richard Middle Thomas Last Ford		4. DATE OF DEATH Month Oct Day 2 Year 19 56.	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1929
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min. 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Operator		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Richard Andrew Ford		14. MOTHER'S MAIDEN NAME Beatrice Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11	
17. INFORMANT Ruth B. Ford		Address 336 63rd St N. E. Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Severence of thoracic aorta, descending branch (c) Severence of thoracic aorta, descending branch DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an auto in collision with another auto.	
20c. TIME OF INJURY Month, Day, Year Hour 2:35 m. 10-2-56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Fairmont Heights, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Oct. 2, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.6.56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire		ADDRESS 1820 9th St., N.W. Washington, D. C.	
24a. REC'D BY REGISTRAR DATE OCT 5 '56		24b. REGISTRAR'S SIGNATURE Alfred Smith	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		POST-MORTEM EXAMINATION	
FINDINGS		OPINION		SIGNATURE OF EXAMINER		DATE	

Hemorrhage and shock
Beverance of alcoholic drinks, decreasing in amount

John A. Williams, Jr., M.D.
Baltimore, Md.

10-2-20

OCT 5 1920

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10606

10567

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2260-Lewisdale Drive				d. STREET ADDRESS 2260 - Lewisdale Drive			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Archie Middle Madonsa Last Fortado				4. DATE OF DEATH Month 10 Day 24 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Progressman Ret. Wash. Navy Yard		10b. KIND OF BUSINESS OR INDUSTRY Jacksonville, Ill.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Gladys A. Fortado		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cardiovascular Renal Disease DUE TO (c) Cardiovascular Renal Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/26 56		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
22d. LOCATION (City, town, or county) (State) Chambersburg Pa.							
23. FUNERAL DIRECTOR'S SIGNATURE Waller's Funeral Home, Inc.				ADDRESS Wt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE OCT 29 1956	
24b. REGISTRAR'S SIGNATURE Della B. Burtette				DATE SIGNED 10-24-56			

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John A. Bortch		Male		30 Years	
Date of Death		Place of Death		Cause of Death	
October 30, 1956		Dallas, Texas		Acute Myocardial Infarction	
Time of Death		Manner of Death		Medical History	
10:00 AM		Natural		None	
Signature of Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. 2

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10607

CERTIFICATE OF DEATH

10568

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED First Middle Last MYRTLE M. FOWLER				4. DATE OF DEATH Month Day Year Oct. 5th. 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18- Jan. 1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Moore				14. MOTHER'S MAIDEN NAME Nettie Langley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address M. Estelle Richards (Clinton, Maryland)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive cardiac failure 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus (c) Cardiovascular Renal Disease						INTERVAL BETWEEN ONSET AND DEATH One day 5 yrs unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 1, 1956 to Oct 5, 1956 , that I last saw the deceased alive on Oct 5, 1956 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE Paul C VanNatta				M.D. 5440 Silver Hill Rd SE Washington 28 DC			
PHYSICIAN'S NAME (Type) PAUL C VANNATTA							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8-56		22c. NAME OF CEMETERY OR CREMATORY Oedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				ADDRESS 1661- Good Hope Rd. SE Washington, D.C.		24a. REC'D BY REGISTRAR OCT 8 1956	
				24b. REGISTRAR'S SIGNATURE Carroll Campbell			

CERTIFICATE OF DEATH

Name of Deceased John E. Moore		Sex Male		Age 45		Date of Birth 1911	
Place of Birth Baltimore, Md.		Usual Residence Baltimore, Md.		Cause of Death Heart Disease		Manner of Death Natural	
Occupation Salesman		Education High School		Date of Death Oct 8, 1956		Place of Death Home	
Signature of Physician [Signature]		Signature of Registrar [Signature]		Signature of Coroner [Signature]		Signature of Medical Examiner [Signature]	
Name of Physician Dr. [Name]		Name of Registrar [Name]		Name of Coroner [Name]		Name of Medical Examiner [Name]	
Address of Physician [Address]		Address of Registrar [Address]		Address of Coroner [Address]		Address of Medical Examiner [Address]	
Telephone of Physician [Number]		Telephone of Registrar [Number]		Telephone of Coroner [Number]		Telephone of Medical Examiner [Number]	
Name of Hospital [Name]		Name of Nursing Home [Name]		Name of Sanatorium [Name]		Name of Other Institution [Name]	
Address of Hospital [Address]		Address of Nursing Home [Address]		Address of Sanatorium [Address]		Address of Other Institution [Address]	
Telephone of Hospital [Number]		Telephone of Nursing Home [Number]		Telephone of Sanatorium [Number]		Telephone of Other Institution [Number]	
Name of Undertaker [Name]		Name of Funeral Home [Name]		Name of Burial Place [Name]		Name of Cemetery [Name]	
Address of Undertaker [Address]		Address of Funeral Home [Address]		Address of Burial Place [Address]		Address of Cemetery [Address]	
Telephone of Undertaker [Number]		Telephone of Funeral Home [Number]		Telephone of Burial Place [Number]		Telephone of Cemetery [Number]	

BUREAU V. S.

OCT 8 1956

RECEIVED

10608

CERTIFICATE OF DEATH

Reg. Dist. No.

230

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Md</u>				d. STREET ADDRESS <u>11240 Baltimore Blvd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11240 Balto. Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Less Juvor</u>				4. DATE OF DEATH <u>Oct 5 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 Feb. 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Will (unknown)</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>unk</u>			
17. INFORMANT <u>Ruby Juvor</u> Address <u>same as #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>Diabetes</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death</u> <u>2 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>56</u> , to <u>Oct 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 2</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>10-6-56</u>			
PHYSICIAN'S NAME (Type) <u>L.W. Malin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md</u>				24a. REC'D BY REGISTRAR <u>11 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10608

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. RACE <i>White</i></p>	
<p>5. DATE OF DEATH <i>Oct 11 1956</i></p>		<p>6. TIME OF DEATH <i>10:00 AM</i></p>	
<p>7. PLACE OF DEATH <i>Home</i></p>		<p>8. CITY <i>Baltimore</i></p>	
<p>9. COUNTY <i>Harford</i></p>		<p>10. STATE <i>Md.</i></p>	
<p>11. OCCUPATION <i>Teacher</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MANNER OF DEATH <i>Natural</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. DATE OF REGISTRATION <i>Oct 11 1956</i></p>	

BUREAU V. B.

OCT 11 1956

RECEIVED

1. Name of Registrar
2. Date of Registration
3. City
4. County
5. State

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10570

Reg. Dist. No.

10609

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Hills		c. LENGTH OF STAY IN 1b 5 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3419 Stanford Street		e. STREET ADDRESS 3419 Stanford Street	
3. NAME OF DECEASED (Type or print) Caroline Bell Gantner		4. DATE OF DEATH Month October Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1892
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Mnths Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hosea Rogers		14. MOTHER'S MAIDEN NAME Nancy B. LeFoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George E. Gantner,		Address same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracranial hemorrhage 331X DUE TO Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 14, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY George Wash. Cem.		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		24. REC'D BY REGISTRAR W. D. C.	
25. FUNERAL DIRECTOR'S ADDRESS 4812 Georgia Ave. N. Wash. D. C.		26. REGISTRAR'S SIGNATURE W. D. C.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		George + Catherine, same address	
Sex		Male	
Age		5 years	
Date of Birth		Oct. 26, 1922	
Place of Birth		Stamford, Conn.	
Usual Residence		319 Stamford Street	
Cause of Death		Sudden	
Occupation		None	
Signature of Physician		George + Catherine	

1922 X 1/2 Fee

BUREAU V. 2

OCT 18 1956

RECEIVED

George + Catherine, same address

John T. Maloney, M.D.

Best Funeral Home
 4815 George Ave. S. E.
 Seattle, Wash. 4

10571

Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Brentwood c. LENGTH OF STAY IN 1b 34 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Brontwood d. STREET ADDRESS 4008 Allison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Alice Isabelle Gilbert First Middle Last 4. DATE OF DEATH October 24, Month Day Year 1956						
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/73	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bloomfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alexander Scott			14. MOTHER'S MAIDEN NAME Jonnie Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Esther M. Jones Address 4008 Allison Street		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						INTERVAL BETWEEN ONSET AND DEATH Sub
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) NONE						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE
20c. TIME OF INJURY Month, Day, Year Nov 23, 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State) NONE
21. I certify that I attended the deceased from 8-15, 1954 to 10-24, 1956 that I last saw the deceased alive on 10-23, 1956 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1901 11th St., N.W., Wash., D.C. DATE SIGNED 10-24-56 ACTUAL SIGNATURE J. C. Oliver M.D. PHYSICIAN'S NAME (Type) J. C. Oliver						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-56		22c. NAME OF CEMETERY OR CREMATORY Carter Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Murikirk, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. M. Murr ADDRESS				24a. REC'D BY REGISTRAR DATE OCT 26 '56		24b. REGISTRAR'S SIGNATURE Robert J. M. Murr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...ca. 1000 - 1050

BUREAU V. S.

1956 OCT 26

RECEIVED

S.S. Harkins Unit #2 "P-0581"

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
106:0 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10572
Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 73rd Street Extended			d. STREET ADDRESS 73rd Street Extended		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle Lee Last Glass			4. DATE OF DEATH Month October Day 6 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 17, 1888	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Charles Edward Glass			14. MOTHER'S MAIDEN NAME Vio Glass ELVIRA GLASS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Lucy Virginia Cox, Same as # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10/10/56		22c. NAME OF CEMETERY OR CREMATORY Wash. Natl.
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers			24a. REC'D BY REGISTRAR DATE Oct. 9, 1956		24b. REGISTRAR'S SIGNATURE Carrie F. Campbell

MAINTAIN STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased George		Sex Male		Age 100		Date of Birth June 1, 1900		Place of Birth Virginia		Date of Death Oct 11, 1956	
Residence 1000		Occupation None		Cause of Death Cardiovascular renal disease		Manner of Death Natural		Medical History None		Postmortem Examination None	
Signature of Physician James I. [illegible]		Signature of Medical Examiner [illegible]		Signature of Coroner [illegible]		Signature of [illegible] [illegible]		Signature of [illegible] [illegible]		Signature of [illegible] [illegible]	

BUREAU V. A.

OCT 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10567

CERTIFICATE OF DEATH

10573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESLEY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD (Univ. Pk.)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>4416 Colchester Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Samuel M. Gruber</u>				4. DATE OF DEATH <u>10-11-56</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-12-68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Margret J. / ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>211 09 0517A</u>		17. INFORMANT <u>Lillian B. Gruber</u> Address <u>Same as # 2 (Wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>199.8</u> DUE TO <u>CARCINOMA BLADDER & PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Sept 56</u> to <u>Oct 56</u> , that I last saw the deceased alive on <u>10-11</u> 19 <u>56</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. L. Etienne</u>				ADDRESS (Street, city or town, state) <u>4713-BERWYN Rd College Park, Md</u>			
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>				DATE SIGNED <u>10-11-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McKeesport, Pa.</u>		22d. LOCATION (City, town, or county) (State) <u>McKeesport, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Paschi Sme</u>				ADDRESS <u>Hyatt, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10-11-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Paul</u>			

CERTIFICATE OF DEATH

DATE OF DEATH OCT 15 1956		PLACE OF DEATH HOME	
DECEASED JAMES E. GIBSON		SEX Male	
AGE 68		RACE White	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH OCT 15 1888	
MARRIAGE Married		DATE OF MARRIAGE 1910	
NAME OF SPouse Mary E. Gibson		NAME OF CHILDREN James E. Gibson Jr.	
NAME OF PHYSICIAN Dr. J. E. Gibson		NAME OF HOSPITAL None	
NAME OF FUNERAL HOME J. E. Gibson		NAME OF BURIAL PLACE None	
NAME OF NEXT OF KIN J. E. Gibson		NAME OF WITNESS J. E. Gibson	
NAME OF REGISTRAR J. E. Gibson		NAME OF CLERK J. E. Gibson	

BUREAU V. S.

OCT 15 1956

RECEIVED

10568

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>md</u> b. COUNTY <u>PG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. LENGTH OF STAY IN <u>42 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George's Hosp</u>				e. STREET ADDRESS <u>1120-76th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Will</u> Middle <u>Rogers</u> Last <u>Hall</u>				4. DATE OF DEATH <u>10-9-56</u> Month <u>10</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-28-38</u> yrs. <u>18</u>	9. AGE (In years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby Sitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				17. INFORMANT <u>Hospital</u> Address <u>Prince Gen. Co.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>518x</u> DUE TO <u>Brachiocephalic Fistula</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Resection of left upper lobe</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unresolved Pneumonia of left lung</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8:30</u> , 19 <u>56</u> , <u>10/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/9/56</u> , 19 <u>56</u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>George William Ware</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>George William Ware</u> M.D.							
PHYSICIAN'S NAME (Type) <u>GEORGE WILLIAM WARE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Brimm Rd. SE D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Washington</u> ADDRESS <u>1809 467 N. St. N.W.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u> </u>	
				DATE <u>OCT 15 '56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		OCCUPATION	
PREVIOUS ILLNESS		HISTORY OF DEATH	
SIGNS AND SYMPTOMS		TESTS AND EXAMINATIONS	
TREATMENT		PATHOLOGICAL FINDINGS	
POST-MORTEM EXAMINATION		LABORATORY TESTS	
CORONER'S FINDINGS		MEDICAL OPINION	
FAMILY HISTORY		SOCIAL HISTORY	
LEGAL FINDINGS		FINAL DISPOSITION	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. 8

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10569

CERTIFICATE OF DEATH

Reg. Dist. No.

10578

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>13 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Henry</u> Last <u>Henry</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-1919</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counter Girl</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Major Hines</u>			
14. MOTHER'S MAIDEN NAME <u>Daisy Hines</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>			
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Daisy Hines</u> Address <u>Capitol Hill 157 Columbia Ave Viewmont</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema.</u> <u>581.0</u> DUE TO (b) <u>Anasarca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertrophic Portal Cirrhosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 month</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>C. Louis Mendel</u> M.D. <u>1006 College Ave College Park Md 10/19/56</u>			DATE SIGNED <u>10/19/56</u>		
PHYSICIAN'S NAME (Type) <u>C. LOUIS MENDEL M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-22-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county)	(State)	<u>Bethesda Rd S.E. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washburn</u> ADDRESS <u>467 N St NW</u>			24a. REC'D BY REGISTRAR DATE <u>OCT 22 '56</u>	24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

CERTIFICATE OF DEATH

Tab. No. 101

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MEDICAL HISTORY		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

10611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City				c. LENGTH OF STAY IN 1b Cottage City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3805 Parkwood Street				d. STREET ADDRESS 3805 Parkwood Street			
3. NAME OF DECEASED (Type or print) First Charles Middle Harvey Last Hickey				4. DATE OF DEATH Month October Day 12 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-1889	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired boiler maker				10b. KIND OF BUSINESS OR INDUSTRY Heating		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edgar Hickey				14. MOTHER'S MAIDEN NAME Alice ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Grace Hickey, Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 14, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10/15/56		Fort Lincoln		Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gacek sons Hyattsville Md				ADDRESS		24a. REC'D BY REGISTRAR OCT 17 1956	
						24b. REGISTRAR'S SIGNATURE A. H. Hedrich	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased Charles Henry White		Sex Male	
Date of Birth 2-10-1889		Age 67	
Place of Birth Maryland		Race White	
Occupation Electrician		Marital Status Married	
Date of Death October 12, 1956		Place of Death 1007 Parkwood Street, Baltimore City	
Cause of Death Cardiovascular renal disease		Manner of Death Natural	

Cardiovascular renal disease
Acute congestive heart failure

BUREAU V. 31

OCT 17 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10580

10612

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 247

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek				c. LENGTH OF STAY IN 1b 30 Yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First RICHARD Middle EDWARD Last HICKS				4. DATE OF DEATH Month 10/5/56 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 March 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Mack Hicks				14. MOTHER'S MAIDEN NAME Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes (If yes, give year or dates of service) NW1				16. SOCIAL SECURITY NO. ?			
17. INFORMANT Lena E. Hicks				1231 D. Street, N.E. Washington, D.C. (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/6/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10/11/56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Fort Myer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co				ADDRESS 1432 You St. NW		24a. REC'D BY REGISTRAR DATE 10/15/56	
						24b. REGISTRAR'S SIGNATURE Carroll Campbell	

MEDICAL CERTIFICATION

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Manner of death: [illegible]
10. Signature of medical examiner: [illegible]
11. Date of certification: [illegible]

RECEIVED
OCT 15 1956
BUREAU V. 2

10613

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Upper Marlboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Croom Station Rd., & Rt. #301.		d. STREET ADDRESS Croom Station Rd., & Rt.#301	
3. NAME OF DECEASED (Type or print) First Margaret Middle Johns Last Hill		4. DATE OF DEATH Month Oct. Day 16 Year 1956.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Isaac Hill	
14. MOTHER'S MAIDEN NAME Henrietta Sasseer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. ---		17. INFORMANT William S. Hill Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive Heart Failure 725X DUE TO (b) Arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Secondary Anemia			INTERVAL BETWEEN ONSET AND DEATH 10 days 4 yrs 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 Jan 16		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 56 , to Oct 16 , 19 56 , that I last saw the deceased alive on Oct 16 , 19 56 , and that death occurred at 4:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/16/56			
ACTUAL SIGNATURE James G. Sasseer M.D.		PHYSICIAN'S NAME (Type) James G. Sasseer Upper Marlboro, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/18/56	22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Brothers Address Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE 191956	24b. REGISTRAR'S SIGNATURE A. H. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CHURCH</p>	
<p>19. SIGNATURE OF CEMETERY</p>		<p>20. SIGNATURE OF INTERVIEWER</p>	
<p>21. SIGNATURE OF INTERVIEWER</p>		<p>22. SIGNATURE OF INTERVIEWER</p>	
<p>23. SIGNATURE OF INTERVIEWER</p>		<p>24. SIGNATURE OF INTERVIEWER</p>	
<p>25. SIGNATURE OF INTERVIEWER</p>		<p>26. SIGNATURE OF INTERVIEWER</p>	
<p>27. SIGNATURE OF INTERVIEWER</p>		<p>28. SIGNATURE OF INTERVIEWER</p>	
<p>29. SIGNATURE OF INTERVIEWER</p>		<p>30. SIGNATURE OF INTERVIEWER</p>	
<p>31. SIGNATURE OF INTERVIEWER</p>		<p>32. SIGNATURE OF INTERVIEWER</p>	
<p>33. SIGNATURE OF INTERVIEWER</p>		<p>34. SIGNATURE OF INTERVIEWER</p>	
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<p>41. SIGNATURE OF INTERVIEWER</p>		<p>42. SIGNATURE OF INTERVIEWER</p>	
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<p>55. SIGNATURE OF INTERVIEWER</p>		<p>56. SIGNATURE OF INTERVIEWER</p>	
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<p>59. SIGNATURE OF INTERVIEWER</p>		<p>60. SIGNATURE OF INTERVIEWER</p>	
<p>61. SIGNATURE OF INTERVIEWER</p>		<p>62. SIGNATURE OF INTERVIEWER</p>	
<p>63. SIGNATURE OF INTERVIEWER</p>		<p>64. SIGNATURE OF INTERVIEWER</p>	
<p>65. SIGNATURE OF INTERVIEWER</p>		<p>66. SIGNATURE OF INTERVIEWER</p>	
<p>67. SIGNATURE OF INTERVIEWER</p>		<p>68. SIGNATURE OF INTERVIEWER</p>	
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<p>71. SIGNATURE OF INTERVIEWER</p>		<p>72. SIGNATURE OF INTERVIEWER</p>	
<p>73. SIGNATURE OF INTERVIEWER</p>		<p>74. SIGNATURE OF INTERVIEWER</p>	
<p>75. SIGNATURE OF INTERVIEWER</p>		<p>76. SIGNATURE OF INTERVIEWER</p>	
<p>77. SIGNATURE OF INTERVIEWER</p>		<p>78. SIGNATURE OF INTERVIEWER</p>	
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<p>81. SIGNATURE OF INTERVIEWER</p>		<p>82. SIGNATURE OF INTERVIEWER</p>	
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<p>91. SIGNATURE OF INTERVIEWER</p>		<p>92. SIGNATURE OF INTERVIEWER</p>	
<p>93. SIGNATURE OF INTERVIEWER</p>		<p>94. SIGNATURE OF INTERVIEWER</p>	
<p>95. SIGNATURE OF INTERVIEWER</p>		<p>96. SIGNATURE OF INTERVIEWER</p>	
<p>97. SIGNATURE OF INTERVIEWER</p>		<p>98. SIGNATURE OF INTERVIEWER</p>	
<p>99. SIGNATURE OF INTERVIEWER</p>		<p>100. SIGNATURE OF INTERVIEWER</p>	

BUREAU V. S.

OCT. 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10570

CERTIFICATE OF DEATH

Reg. Dist. No.

10582

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>5424 55th Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Constance</u> Last <u>Hooker</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1956</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25 - 1901</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>				11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick McCrory</u>						14. MOTHER'S MAIDEN NAME <u>Catherine Clark</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Philip K. Hooker</u> Address <u>5424-55th Pl. Riverdale</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma of Cervix.</u> DUE TO (c) <u>3yrs.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>9/3/56</u> , 19 <u>56</u> , to <u>10/11/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/10/56</u> , 19 <u>56</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.													
ACTUAL SIGNATURE <u>Frederick E. Musser</u> M.D.						ADDRESS (Street, city or town, state) <u>7409 Varnum St</u>				DATE SIGNED <u>10/11/56</u>			
PHYSICIAN'S NAME (Type) <u>Landoner Hills, Md.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nati Mem. Pk Cemetery</u>				22d. LOCATION (City, town, or county) <u>Falls Church Virginia</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u>						ADDRESS <u>5801 Cleve. Ave, Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>15 '56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

State and Year

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
HARRIS, M. GORD		M		42		1914		BALTIMORE		MD		USA			
MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED		RE-MARRIED		OTHER			
MARRIED		SINGLE		MARRIED		WIDOWED		DIVORCED		RE-MARRIED		OTHER			
MARRIED		SINGLE		MARRIED		WIDOWED		DIVORCED		RE-MARRIED		OTHER			

DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
10/15/56		BALTIMORE		MD		USA				HEART DISEASE		NATURAL		FARMER	
10/15/56		BALTIMORE		MD		USA				HEART DISEASE		NATURAL		FARMER	
10/15/56		BALTIMORE		MD		USA				HEART DISEASE		NATURAL		FARMER	

NAME OF PHYSICIAN		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		SIGNATURE		TITLE	
DR. J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		PHYSICIAN	
DR. J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		PHYSICIAN	
DR. J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		PHYSICIAN	

NAME OF FUNERAL HOME		ADDRESS		CITY		STATE		COUNTRY		DATE OF INTERMENT		SIGNATURE		TITLE	
HARRIS & SONS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		FUNERAL HOME	
HARRIS & SONS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		FUNERAL HOME	
HARRIS & SONS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		FUNERAL HOME	

NAME OF CORONER		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		SIGNATURE		TITLE	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		CORONER	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		CORONER	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		CORONER	

NAME OF WITNESS		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		SIGNATURE		TITLE	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	

NAME OF WITNESS		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		SIGNATURE		TITLE	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	

NAME OF WITNESS		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		SIGNATURE		TITLE	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	

NAME OF WITNESS		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		SIGNATURE		TITLE	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	

NAME OF WITNESS		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		SIGNATURE		TITLE	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	
J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MD		USA		10/15/56		[Signature]		WITNESS	

BUREAU V. S.

OCT 15 1956

RECEIVED

10/15/56 HARRIS & SONS

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10571
CERTIFICATE OF DEATH

10583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince Georges b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood				c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood Md.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4317 34th St				d. STREET ADDRESS 4317 34th St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle Frank Last Houck				4. DATE OF DEATH Month Oct Day 20 Year 1956									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/24/1871		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Sell Houck				14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Aubrey Houck				Address Brentwood, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive failure, rt + left 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 year 7 years.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____, 1947, to _____, 19____, that I last saw the deceased alive on _____, 1956, and that death occurred at 12:04 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Ernest E. Cornelsen M.D. 4400 Bowen Rd. SE PHYSICIAN'S NAME (Type) ERNEST E. CORNELSEN M.D. WASHINGTON, D.C.													
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 10/20/56		22c. NAME OF CEMETERY OR CREMATORY Union West Virginia				22d. LOCATION (City, town, or county) West Virginia (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.						24a. REC'D BY REGISTRAR OCT 22 1956		24b. REGISTRAR'S SIGNATURE R. H. Hedrick					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10584

10572

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 6232 Shadyside Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Francis (Frank) M. Jacoby				4. DATE OF DEATH Month Day Year Oct. 17, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis M. Jacoby				14. MOTHER'S MAIDEN NAME Laura C. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Florence M. Jacoby 6232 Shadyside Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x Acute Congestive Failure DUE TO CARDIAC INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CARCINOMA PROSTATE (c)						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 1 1/2 yrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1954 to 17 Oct. 1956 that I last saw the deceased alive on Oct. 16, 1956, and that death occurred at 6:30 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Sidney W. Lowry				ADDRESS (Street, city or town, state) 7200 MARLBORO PIKE SE. 28 DC			
PHYSICIAN'S NAME (Type) S. W. LOWRY				DATE SIGNED WASH. 28 DC 10/17/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/56		22c. NAME OF CEMETERY OR CREMATORY Hillside		22d. LOCATION (City, town, or county) (State) Philadelphia Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home 4812 Georgia Ave. N.W.				24a. REC'D BY REGISTRAR DATE OCT 19 1956		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10573

CERTIFICATE OF DEATH

10585

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>6 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>Ardmore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Johnson</u> Middle Last				4. DATE OF DEATH <u>October</u> Month <u>27</u> Day <u>19</u> Year <u>56</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-13-1902</u>		
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man Construction</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>				11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Eabin Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>74</u>		17. INFORMANT <u>Viola C. Johnson</u>		Address <u>3rd St. Admou</u> <u>Landover Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1</u> <u>Liver's Cirrhosis</u> <u>581.1</u> DUE TO <u>CAENNECIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2</u> <u>Coma (Hepatic)</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		
20f. (City or town) <u> </u>				(County) <u> </u>		(State) <u> </u>		
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>56</u> , to <u>10-27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-27</u> , 19 <u>56</u> , and that death occurred at <u>10, 20M</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Albert Rath</u> M.D.				ADDRESS (Street, city or town, state) <u>RIVERDALE, MARYLAND</u>				
PHYSICIAN'S NAME (Type) <u>ALBERT RATH</u>				DATE SIGNED <u>10-28-56</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>				ADDRESS <u>512 11th St. S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 30 56</u>		
24b. REGISTRAR'S SIGNATURE <u> </u>				24c. REGISTRAR'S SIGNATURE <u> </u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 OCT 30

RECEIVED

Robert

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10574

CERTIFICATE OF DEATH

10586

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P. GS.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. BRENTWOOD</u>		c. LENGTH OF STAY IN 1b <u>50 YEARS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. BRENTWOOD</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3918 Webster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3918 Webster</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OTHA</u> First <u>HERBERT</u> Middle <u>JOHNSON</u> Last		4. DATE OF DEATH <u>10-15</u> Month <u>10</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 17, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Delivery Ice and Coal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ICE AND COAL</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OTHA H. JOHNSON SR.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fowler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Sophia Randall</u>		Address <u>3918 Webster St. N. Brentwood, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Nephritis</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr - 1953</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-2-</u> , 19 <u>56</u> , to <u>10-15-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-14-</u> , 19 <u>56</u> , and that death occurred at <u>1:52</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. W. Spiller</u>		ADDRESS (Street, city or town, state) <u>4506 R.I. Ave. Brentwood Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. W. SPILLER</u>		DATE SIGNED <u>10-15-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u>		ADDRESS <u>1820 9th St., N.W. Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>OCT 18 '56</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

OCT 18 1956

RECEIVED
OCT 18 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10614
CERTIFICATE OF DEATH

10587

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 447 - Delaware Ave., S.W.	
3. NAME OF DECEASED (Type or print) First William Middle P. Last Jones		4. DATE OF DEATH Month October Day 19 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 9, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement worker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wash Jones		14. MOTHER'S MAIDEN NAME Rose ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. (can't find)	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of left lung 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 5, 1956 to Oct. 19, 1956, that I last saw the deceased alive on October 19, 1956, and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis DeCoste		ADDRESS (Street, city or town, state) Glenn Dale Hospital	
DATE SIGNED 10/19/56			
PHYSICIAN'S NAME (Type) Francis DeCoste			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/56	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) 4600 Benning Rd. S.E. Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Fulkerson		ADDRESS 1702-12th St N.W.	
24a. REC'D BY REGISTRAR DATE 10/19/56		24b. REGISTRAR'S SIGNATURE W. L. Wynn	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10588

10545

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. LENGTH OF STAY IN 1b 13 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		d. STREET ADDRESS 6309 Sligo Parkway	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNEST Middle WINFIELD Last KILTON				4. DATE OF DEATH Month October Day 29 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1909		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Repairman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest D. Kilton				14. MOTHER'S MAIDEN NAME Margaret Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-3314		17. INFORMANT Mrs. Vera S. Kilton, Parkway, W. Hyatts., Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH few minutes						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1952 to Oct 29 , 19 56 , that I last saw the deceased alive on Oct 28 , 19 56 , and that death occurred at 6:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6220 Ager Road, Hyattsville, Md. DATE SIGNED 10/29/56 ACTUAL SIGNATURE Ernest J. Parent M.D. PHYSICIAN'S NAME (Type) ERNEST J. PARENT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1956		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO. Riverdale, Md.				24a. REC'D BY REGISTRAR DATE Oct 30 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Senese	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
J. J. J. J. J.		M		35		JAN 1 1910		BALTIMORE		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		SEX	
J. J. J. J. J.		H		M		C		W		W		M	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
JAN 1 1956		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN		MEDICINE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
JAN 1 1956		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN		MEDICINE	

BUREAU V. B.

NOV 1 1956

RECEIVED

CHURCHES CO. BALTIMORE, MD.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10575 CERTIFICATE OF DEATH

Reg. Dist. No.

10589

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 5800 11th Avenue			
3. NAME OF DECEASED (Type or print) Evelyn Virginia King				4. DATE OF DEATH Month October Day 29 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John K. Seay				14. MOTHER'S MAIDEN NAME Bessie Elizabeth Seay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Clifton R King				Address Hyattsville, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-28, 1956, to 10-29, 1956, that I last saw the deceased alive on 10-28, 1956, and that death occurred at 12:15 M, from the causes and on the date stated above. ACTUAL SIGNATURE A. Deitz M.D. Hyattsville Md. DATE SIGNED 10-29-56 PHYSICIAN'S NAME (Type) A. DEITZ							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Oct 31, 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE OCT 30 56		24b. REGISTRAR'S SIGNATURE	

2

100

BUREAU V. S.

1956 OCT 30

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10590

10615

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Seat Pleasant</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Seat Pleasant</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5980 Addison Road</u>				d. STREET ADDRESS <u>5980 Addison Road</u>			
3. NAME OF DECEASED (Type or print) <u>George Wilbert King</u>				4. DATE OF DEATH <u>Oct 22 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 11 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Street car repair</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transit Co</u>		11. BIRTHPLACE (State or foreign country) <u>Laurel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Franklin King</u>				14. MOTHER'S MAIDEN NAME <u>Annie H. Marks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-10-7724</u>		17. INFORMANT <u>Mrs Anna May Sargent, 5870 Addison Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronehogenic Carcinoma (Lungs)</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>June 1 1956</u> (onset)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>56</u> , to <u>Oct 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>56</u> , and that death occurred at <u>11:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Suit Ritchie</u>				ADDRESS (Street, city or town, state) <u>7005 Ritchie Road SE</u>		DATE SIGNED <u>10/22/56</u>	
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie</u>				Washington 27 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-26-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Friendship Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>	
				DATE <u>Oct 25 1956</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. GIBSON		AGE 65 Yrs	
SEX Male		DATE OF BIRTH Jan 15 1890	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH Oct 25 1956		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. M. Gibson		SIGNATURE OF WITNESSES J. M. Gibson	
SIGNATURE OF REGISTRAR J. M. Gibson		SIGNATURE OF CLERK J. M. Gibson	

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OCT 25 1956
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10576 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 7310 84th P. ace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kenneth Middle Knab Last				4. DATE OF DEATH Month October Day 27 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2nd, 1954	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 11 Days		IF UNDER 24 HRS. Hours 11 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
						12. CITIZEN OF WHAT COUNTRY? U.S.A2	
13. FATHER'S NAME Gerald Knab				14. MOTHER'S MAIDEN NAME Catherine DeLacy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Father; same address Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Bronchopneumonia (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral palsy--- Congenital heart disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF oct 30, 1956		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
22d. LOCATION (City, town, or county) (State) Yeadon Pennsylvania							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE OCT 30 '56		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - DIVISION 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED George J. ...		DATE OF DEATH October 27, 1956	
PLACE OF DEATH Home		CITY AND COUNTY Baltimore, Maryland	
AGE 60		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION None		MARRIAGE Married	
PREVIOUS ILLNESS None		CAUSE OF DEATH Myocardial infarction	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER [Signature]	
DATE OF EXAMINATION October 27, 1956		PLACE OF EXAMINATION Home	
TIME OF EXAMINATION 10:00 AM		NAME OF WITNESSES [Names]	
SIGNATURE OF WITNESSES [Signatures]		DATE OF SIGNATURE October 27, 1956	

BUREAU V. S.

OCT 30 1956

RECEIVED

10577

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 29 Hours			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Hgts				36			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hosp				d. STREET ADDRESS 730 57th Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Fritz First Middle Last Knudsen				4. DATE OF DEATH Month October Day 18 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-16-83	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Manager Center Market			
11. BIRTHPLACE (State or foreign country) DENMARK				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HANS PETER KNUDSEN				14. MOTHER'S MAIDEN NAME ANNA HUYER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 2504-10 ST NE DC			
17. INFORMANT CECILIA E HORTON				Address 2504-10 ST NE DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 550.1 Complete Heart Block DUE TO (b) Intestinal Obstruction DUE TO (c) Periappendiceal Abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old left pneumonectomy for bronchogenic carcinoma							INTERVAL BETWEEN ONSET AND DEATH 1 year 4 days 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July, 1955, to 18 October, 1956, that I last saw the deceased alive on Oct. 18, 1956, and that death occurred at 8:45 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Max M. Herzberg				ADDRESS (Street, city or town, state) 7016 GREGG ST, SEAT-PLEASANT, MD.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Dr. Max Herzberg							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10/21/56		22c. NAME OF CEMETERY OR CREMATORY Episcopal		22d. LOCATION (City, town, or county) (State) Forestville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sons Co - DC				24a. REC'D BY REGISTRAR DATE 10-24-56		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED PATRICK J. HANRAHAN		SEX MALE	
DATE OF BIRTH JAN 15 1917		PLACE OF BIRTH NEW YORK	
OCCUPATION LABORER		MARITAL STATUS SINGLE	
CAUSE OF DEATH MYOCARDIAL INFARCTION		MANNER OF DEATH NATURAL	
DATE OF DEATH OCT 20 1956		PLACE OF DEATH HOME	
SIGNATURE OF PHYSICIAN J. H. HANRAHAN		SIGNATURE OF REGISTRAR J. H. HANRAHAN	

BUREAU OF HEALTH

OCT 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10594

10578

CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanell</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanell</u>	
c. LENGTH OF STAY IN 1b <u>33 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>704 Main Street</u>		d. STREET ADDRESS <u>704 Main Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Elder</u> Last <u>Lepore</u>		4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2 1890</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Emmitsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Basil Elder</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Hess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Alfred Lepore, Lanell, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, General</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis, originally</u> DUE TO (c) <u>of descending colon.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/14</u> , 19 <u>56</u> to <u>10/2</u> , 19 <u>56</u> that I last saw the deceased alive on <u>10/2</u> , 19 <u>56</u> , and that death occurred at <u>1.15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B P Warren</u> M.D. <u>Lanell</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>B P WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE TIME OF <u>10/4/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lanell Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Carradine</u>		ADDRESS <u>Lanell Md.</u>	
24a. REC'D BY REGISTRAR <u>W. H. Carradine</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Carradine</u>	

BUREAU V. S.

9561 6 OCT 9 1956

RECEIVED

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10596

10579

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. STREET ADDRESS <u>4102-53rd Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First Middle Last <u>humsden</u>				4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-26-1858</u>	
9. AGE (In years last birthday) <u>98</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Spruell</u>				14. MOTHER'S MAIDEN NAME <u>Emily</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mattie S Heller</u> Address <u>4102-53rd Ave Bladensburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>51</u> , to <u>1360</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 Oct</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Mattingly</u>				ADDRESS (Street, city or town, state) <u>2200 R. F. Ave N.E.</u> DATE SIGNED <u>18 Oct. 1956</u>			
PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>1400 Chapin St. N.W.</u>				24a. REC'D BY REGISTRAR <u>Oct. 15 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L.H. Hedrick</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES EARL RAY		MALE		39		JAN 5 1928		MOBILE, ALABAMA		ATTORNEY	
RESIDENCE		MARRIED		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
2000 E. CALHOUN ST., BALTIMORE, MD.		YES		HEART DISEASE		NATURAL		BALTIMORE, MD.		OCT 14 1968	
FATHER		MOTHER		EDUCATION		RELIGION		SPECIAL OCCASION		SIGNATURE OF DECEASED	
JAMES EARL RAY, JR.		MARY EARL RAY		HIGH SCHOOL		METHODIST		NONE		NONE	
DATE OF INTERVIEW		INTERVIEWED BY		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
OCT 15 1968		J. W. CAMPBELL		OCT 14 1968		BALTIMORE, MD.		OCT 14 1968		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. W. CAMPBELL		J. W. CAMPBELL		J. W. CAMPBELL		J. W. CAMPBELL		J. W. CAMPBELL		J. W. CAMPBELL	

BUREAU V. S.

OCT 18 1968

RECEIVED

10616

CERTIFICATE OF DEATH

10597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7903-Dist. Heights Parkway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights Md.</u> d. STREET ADDRESS <u>7903-Dist. Heights Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>SARA</u> First <u>LILLIAN</u> Middle <u>LYBRAND</u> Last				4. DATE OF DEATH Month <u>10</u> - Day <u>10</u> Year <u>1956</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23, 1899</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Matthias J. Rucker</u>						14. MOTHER'S MAIDEN NAME <u>Anna Johnson</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Louis L. Scott</u> Address <u>7903-Dist. Hgts. Pkwy</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Cell Carcinoma of Pteryx</u> <u>148X</u> DUE TO <u>Generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>1955-1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u> </u> 19 <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Nov. 26</u> , 19 <u>55</u> , to <u>Oct. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 10</u> , 19 <u>56</u> , and that death occurred at <u>1:40 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>													
ACTUAL SIGNATURE <u>Bernard Katzen</u> M.D. <u>3520-Minn. Ave. S.E.</u>													
PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN M.D.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>				22d. LOCATION (City, town, or county) <u>Wagner, S. Carolina</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Jr.</u> ADDRESS <u>577-11 St. L.E.</u>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>A. H. H. H.</u>					
DATE <u>OCT 15 1956</u>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10580

CERTIFICATE OF DEATH

10598239
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>29 AVONDALE ST.</u>				d. STREET ADDRESS <u>29 AVONDALE ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE</u> ² First <u>AGNES</u> ¹ Middle <u>MALLONEE</u> Last				4. DATE OF DEATH <u>9</u> Month <u>12</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 22, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAKERY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LEONARD J. MALLONEE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ANN HUSTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>MRS NORA LEATHERWOOD LAUREL, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart Failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/20, 1956</u> , to <u>10/12, 1956</u> , that I last saw the deceased alive on <u>10/12, 1956</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank L. Weaver, Jr.</u> M.D. 320 Montgomery, Laurel				DATE SIGNED <u>10/12/56</u>			
PHYSICIAN'S NAME (Type) <u>FRANK L. WEAVER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>144 HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson, Laurel, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 17-56</u>		24b. REGISTRAR'S SIGNATURE <u>M. Brashears</u>	

CERTIFICATE OF DEATH

0350

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]	
CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]		PLACE OF BIRTH [Faint, illegible text]	
OCCUPATION [Faint, illegible text]		EDUCATION [Faint, illegible text]		RELIGION [Faint, illegible text]	
MARITAL STATUS [Faint, illegible text]		PREVIOUS MARRIAGES [Faint, illegible text]		PREVIOUS DEATHS [Faint, illegible text]	
SIGNATURE OF DECEASED [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]		SIGNATURE OF PHYSICIAN [Faint, illegible text]	
SIGNATURE OF CORONER [Faint, illegible text]		SIGNATURE OF JURY [Faint, illegible text]		SIGNATURE OF JUDGE [Faint, illegible text]	

BUREAU V. S.

OCT 18 1956

RECEIVED

10617

CERTIFICATE OF DEATH

10599 30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince Georges,		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park Md			c. LENGTH OF STAY in 1b 10 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6501 Queens Chapel Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Alexander Middle Marshall Last			4. DATE OF DEATH Month October Day 13, Year 19 56.		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 16, 1893		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard		11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME James M. Marshall			14. MOTHER'S MAIDEN NAME Margaret Patton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW I (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT John A Marshall Address University Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 5-1 1956 , to 10-13 1956 , that I last saw the deceased alive on 6-10 1956 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED 10-13-56 ACTUAL SIGNATURE A. Deitz M.D. Hyattsville Md PHYSICIAN'S NAME (Type) A. Deitz M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/16/56	22c. NAME OF CEMETERY OR CREMATOR Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.			24a. REC'D BY REGISTRAR 10-15-1956 DATE 24b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		OCT 10 1956		BOSTON, MASS.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPouse		DATE OF BIRTH		PLACE OF BIRTH	
MARRIED		JAN 15 1940		BOSTON, MASS.		MARY J. JONES		JAN 15 1910		BOSTON, MASS.	
EDUCATION		SCHOOLING		REMARKS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
HIGH SCHOOL		8		HEART DISEASE		HEART DISEASE		NATURAL		BOSTON, MASS.	
OCCUPATION		LABORER		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH	
LABORER		OCT 10 1956		BOSTON, MASS.		BOSTON, MASS.		JAMES J. JONES		OCT 10 1956	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. 31

OCT 15 1956

RECEIVED

10581 CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> TOWN <u>LAUREL</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LAUREL SANITARIUM</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BAKIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BAKIMORE</u> TOWN <u>183 VOL 4</u> STREET ADDRESS (If rural give location) <u>2237 KIDEN Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MARY</u> (Middle) <u>ELLEN</u> (Last) <u>MATHEWS</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>10</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>11-16-1870</u>
9. AGE last birthday <u>85</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>8</u> (Days) <u>10</u> (Hours) <u>56</u> (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOLTEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BAKIMORE Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILBUR F. MATHEWS</u>		14. MOTHER'S MAIDEN NAME <u>MANIE MC BRIDE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>HOSPITAL RECORDS</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 334X IMMEDIATE CAUSE (A) <u>CHRONIC BRAIN SYNDROME ASSOCIATED</u> ANTECEDENT CAUSE(S) DUE TO <u>WITH CEREBRAL ARTERIOSCLEROSIS WITH</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>PSYCHOTIC REACTION</u> (C)		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-9</u> , 19 <u>56</u> , to <u>10-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-10</u> , 19 <u>56</u> , and that death occurred at <u>4:34</u> A.M., from the causes and on the date stated above. SIGNATURE <u>Edna P. Korman</u> M.D. ADDRESS <u>LAUREL SANITARIUM</u> DATE SIGNED <u>LAUREL, 10 10 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>10-10-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Bellevue</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. REC'D BY REGISTRAR <u>1956</u> REGISTRAR'S SIGNATURE <u>Thelie Brashear</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Moreno</u> ADDRESS <u>Balto 1</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

REAU V. E.

OCT 11 1956

11

10618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland		c. LENGTH OF STAY IN 1b 45 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANDREA First MISTRETТА Middle MISTRETТА Last		4. DATE OF DEATH Month Oct. Day 23rd. Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21- 1882
9. AGE (In years last birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Salvatore Mistretta		14. MOTHER'S MAIDEN NAME Pietrina Buttone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Lura Mae Mistretta (Wife)		Address 5410 Livingston Rd. SE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition a secondary anemia. 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Liver cirrhosis of undetermined origin DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 16 , 19 56 , to Oct. 23 , 19 56 , that I last saw the deceased alive on Oct. 23 , 19 56 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Etienne Szollosi M.D.		DATE SIGNED Oct 25 1956	
PHYSICIAN'S NAME (Type) Etienne Szollosi		ADDRESS (Street, city or town, state) DR. ETIENNE SZOLLOSI, 2 PARKWAY DR., FOREST HILLS, WASHINGTON (21) D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 26- 56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE 1661- Good Hope Road SE Washington, 20, D.C.		24a. REC'D BY REGISTRAR DATE 25 1956	24b. REGISTRAR'S SIGNATURE Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John W. Smith		Male		45		Jan. 1, 1910		Baltimore, Md.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Physician		High School		Roman Catholic	
Date of Death		Time of Death		Place of Death		Physician		Signature	
Oct. 25, 1956		10:30 A.M.		Home		J. W. Smith		J. W. Smith	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer	
J. W. Smith		J. W. Smith		J. W. Smith		J. W. Smith		J. W. Smith	

BUREAU V. 2

OCT 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10619
 CERTIFICATE OF DEATH

10602

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lanham Severn Road				d. STREET ADDRESS Lanham Severn Road			
3. NAME OF DECEASED (Type or print) First Middle Last Addie Elizabeth Moreland				4. DATE OF DEATH Month Day Year Oct 25, 19 56.			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 9, 1871	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Wilson Crosby				14. MOTHER'S MAIDEN NAME Ann Slei			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Dorothy Blythe Lanham Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio renal disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10-22-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/3 1956, to 10-25 1956, that I last saw the deceased alive on 10-25 1956, and that death occurred at 4:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Hageage				ADDRESS (Street, city or town, state) 3717-38th Ave Cottage City, Md		DATE SIGNED 10-25-56	
PHYSICIAN'S NAME (Type) George J. Hageage							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/56		22c. NAME OF CEMETERY OR CREMATORY Whitfield Cemetery		22d. LOCATION (City, town, or county) Lanham, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE 10/26/56	
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10603

10620

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #2., Box 184				d. STREET ADDRESS Rt. #2., Box 184			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lillie Middle Virginia Last Mullikin				4. DATE OF DEATH Month 10 Day 11 Year 19 56.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1882	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Robert Sweeney				14. MOTHER'S MAIDEN NAME Joanna Norfolk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Pearl Von Garlem Address Rt. #2, Box 184 Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic CV Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 men. 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb , 19 56 , to 11 Oct , 19 56 , that I last saw the deceased alive on 1 Oct , 19 56 , and that death occurred at 3:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R B Sasseer M.D. Upper Marlboro Md DATE SIGNED 13 Oct 56							
PHYSICIAN'S NAME (Type) Robert B. Sasseer				Address Upper Marlboro, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/56		22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE 16 1956			
24b. REGISTRAR'S SIGNATURE A. J. Sedwick							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG205 10-29-56 et

10582

CERTIFICATE OF DEATH

Reg. Dist. No.

10604

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheneley		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George's Gen. Hosp.		d. STREET ADDRESS 3709 - 38th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William F. NALLEY		4. DATE OF DEATH Month Oct. Day 19 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-89
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop Washington D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Nalley		14. MOTHER'S MAIDEN NAME Ann Elizabeth Crutchett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Plummer		Address Daughters	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x Acute pulmonary embolism DUE TO (b) Phlebitis, rt. leg, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hemiplegia, rt. DUE TO (c) Hemiplegia, rt.		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 days 16 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/25, 1950, to 10/19, 1956, that I last saw the deceased alive on 10/18, 1956, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Julius Kauffman, M.D.		ADDRESS (Street, city or town, state) 5102 Annapolis Rd. Bladensburg Md.	
DATE SIGNED 10/19/56			
PHYSICIAN'S NAME (Type) JULIUS KAUFFMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill FT. LINCOLN		22d. LOCATION (City, town, or county) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		ADDRESS Mt. Rainier, Md.	
24a. REC'D BY REGISTRAR DATE OCT 23 '56		24b. REGISTRAR'S SIGNATURE	

90

BUREAU V. E.

OCT 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10583

CERTIFICATE OF DEATH

10606

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>3919 Lshell Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Ann</u> Last <u>O'Connor</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-7-56</u> 9. AGE (In years last birthday) <u>8 days</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Patrick O'Connor</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Marie Hastings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7625</u> DUE TO <u>atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c) <u>8 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct. 7, 1956</u> to <u>Oct. 15, 1956</u> , that I last saw the deceased alive on <u>Oct. 15, 1956</u> , and that death occurred at <u>12:35 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Johann W. Perkins</u> M.D. <u>5301 Hamilton St.</u>				DATE SIGNED <u>10/14/56</u>			
PHYSICIAN'S NAME (Type) <u>Johann W. Perkins, M.D.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Vp.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave. S.E.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 18 56</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith, Md.</u>	

2277325XV2

CERTIFICATE OF DEATH

Form 10-54-1

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		INDUSTRY		TRADE		PROFESSION		VOCATION		SPECIALTY		OTHER			
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DEGREE		OTHER			
RELIGION		METHODIST		ROMAN CATHOLIC		LUTHERAN		PRESBYTERIAN		OTHER		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		MANNER OF DEATH		OTHER			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		OTHER			
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF OTHER		SIGNATURE OF OTHER		SIGNATURE OF OTHER			
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE			

BUREAU V. S.

OCT 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10607

231

10621

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tuxedo			c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tuxedo		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5500 Tuxedo Road				d. STREET ADDRESS 5500 Tuxedo Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Elton Owens				4. DATE OF DEATH Month Day Year October 1, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov, 14, 1915		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10b. KIND OF BUSINESS OR INDUSTRY Express		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Z. Owens				14. MOTHER'S MAIDEN NAME Mattie Watts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-12-7834		17. INFORMANT Address Mother- Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and toxemia</p> <p>491X DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia</p> <p>DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED October 1, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR OCT 4 1956		24b. REGISTRAR'S SIGNATURE <i>R. T. Sedwick</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. Jones	
Age		40 years	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Engineer	
Usual Residence		123 Main St., Boston, Mass.	
Date of Death		October 1, 1956	
Place of Death		Home	
Cause of Death		Myocardial Infarction	
Manner of Death		Natural	
Physician's Name		Dr. J. H. Smith	
Physician's Address		456 North St., Boston, Mass.	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	

BUREAU V. 2

OCT 4 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10608

10622

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u>			
c. LENGTH OF STAY IN 1b <u>25 yrs.</u>				d. STREET ADDRESS <u>7905- Livingston Rd SE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7905- Livingston Rd SE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BERNARD ARTHUR PICKRELL</u>			4. DATE OF DEATH <u>Oct. 20 1956</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23-1889</u>	
				9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Fitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Andrews Air Base</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Ignatius Pickrell</u>				14. MOTHER'S MAIDEN NAME <u>Susan Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Elizabeth V. Pickrell</u> Address <u>7905- Livingston Rd SE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema & Pneumonia</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatous</u> DUE TO (c) <u>Ca. of Lungs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>6 mo</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-25</u> , 19 <u>56</u> , to <u>10-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-19</u> , 19 <u>56</u> , and that death occurred at <u>9:55 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Richard H. Dabson</u> M.D.				SIGNATURE <u>Brangwen</u> MD			
PHYSICIAN'S NAME (Type) <u>Richard H. Dabson</u>				SIGNATURE <u>Brangwen</u> MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Brookview MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros.</u> ADDRESS <u>16615 Wood Hope Rd SE WASH. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 23 '56</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10609

CERTIFICATE OF DEATH

Reg. Dist. No.

242

10623

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION - - - -				d. STREET ADDRESS 5506 Henderson Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) I acapo Pino PIERI				4. DATE OF DEATH October 22, 19 56				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ornamental Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Lucda, ITALY		12. CITIZEN OF WHAT COUNTRY? U.S. of A		
13. FATHER'S NAME Lorenzo Pieri				14. MOTHER'S MAIDEN NAME Catherina Paladini				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-05-0666		17. INFORMANT Mrs. Anita VANNI, 5506 Henderson Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer, Metastatic to Lungs from 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Prostate DUE TO (c) - - - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						INTERVAL BETWEEN ONSET AND DEATH 3 years 3 years +		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - -				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. - - - - 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - -		
20f. (City or town) - - - - (County) - - - - (State) - - - -				20g. (City or town) - - - - (County) - - - - (State) - - - -				
21. I certify that I attended the deceased from December 53, to October 22, 1956, that I last saw the deceased alive on October 22, 1956, and that death occurred at 8:10 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Walcutt W. Gibson				ADDRESS (Street, city or town, state) 2412 Minnesota Avenue S.E.				DATE SIGNED Oct. 22, 1956
PHYSICIAN'S NAME (Type) Walcutt W. GIBSON, M.D.				Washington 20, D.C.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 25, 1956		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) Washington D.C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sons Co. Inc.				ADDRESS - - - -		24a. REC'D BY REGISTRAR DATE 10-24-56		24b. REGISTRAR'S SIGNATURE Carrie Campbell

CERTIFICATE OF DEATH

1. NAME OF DECEASED A. LAST NAME B. FIRST NAME C. MIDDLE NAME		2. SEX A. MALE B. FEMALE	
3. DATE OF BIRTH A. MONTH B. DAY C. YEAR		4. PLACE OF BIRTH A. CITY B. STATE C. COUNTRY	
5. DATE OF DEATH A. MONTH B. DAY C. YEAR		6. PLACE OF DEATH A. CITY B. STATE C. COUNTRY	
7. CAUSE OF DEATH A. DISEASE B. INJURY C. OTHER		8. MANNER OF DEATH A. NATURAL B. ACCIDENTAL C. SUICIDE D. HOMICIDE	
9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS	
15. SIGNATURE OF WITNESS		16. SIGNATURE OF WITNESS	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS	
23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS	
27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS	
29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS	
33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS	
35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS	
39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS	
45. SIGNATURE OF WITNESS		46. SIGNATURE OF WITNESS	
47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS	
51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS	
53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS	
57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS	
59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS	
63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS	
65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS	
69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
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75. SIGNATURE OF WITNESS		76. SIGNATURE OF WITNESS	
77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS	
83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS	
87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS	
89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS	
93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS	
95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS	
99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	

RECEIVED
OCT 25 1956
BUREAU V. M.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7602 MARLBORO PIKE				d. STREET ADDRESS 7602 MARLBORO PIKE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last SARA H E RANDOLPH				4. DATE OF DEATH Month Day Year OCT. 6 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN A. MORRE				14. MOTHER'S MAIDEN NAME KATHERINE F. REIMUTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Wallace L. Randolph		Address 7602 Marlboro Pike Forestville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 8, 1948 to Oct 6, 1956 that I last saw the deceased alive on Oct 4, 1956 , and that death occurred at 2:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin				ADDRESS (Street, city or town, state) 6124 Central Ave		DATE SIGNED 10/6/56	
PHYSICIAN'S NAME (Type) WILLIAM BRAININ				Capitol Hgts Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-9-56		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees Son				ADDRESS 300-4th St N.E. Wash D.C.		24a. REC'D BY REGISTRAR 9-9-56	
				24b. REGISTRAR'S SIGNATURE Corrie J. Campbell			

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

BUREAU V. S.

1956 28 OCT

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10585 CERTIFICATE OF DEATH

10612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBELT, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>6107 Greenbelt Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Sampson</u> Last <u>Sampson</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-81</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tom E. Rippetoe</u>		14. MOTHER'S MAIDEN NAME <u>Susan C Bond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Katherine Sampson Hyattsville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Advanced arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15</u> , 19 <u>48</u> , to <u>10/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/22</u> , 19 <u>56</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Louis Mendel</u>		ADDRESS (Street, city or town, state) <u>1506 COLLEGE AVE</u> DATE SIGNED <u>10/25/56</u>	
PHYSICIAN'S NAME (Type) <u>C. LOUIS MENDEL</u>		<u>COLLEGE PARK MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasche</u>		ADDRESS <u>Hyattsville Md</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 25 '56</u>		24b. REGISTRAR'S SIGNATURE <u>Reed</u>	

CERTIFICATE OF DEATH

10325

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. B.

OCT 25 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10625

CERTIFICATE OF DEATH

10613

Reg. Dist. No.

342

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		d. STREET ADDRESS 4978- Keppler Rd. S.E. Wash. 22	
3. NAME OF DECEASED (Type or print) First Emil Middle John Jacob Last SCHMID		4. DATE OF DEATH Month Oct. 14th Day 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 9, 1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months -- Days -- Hours -- Min. --	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Craftsman Ornamental Iron		10b. KIND OF BUSINESS OR INDUSTRY Iron Works	
11. BIRTHPLACE (State or foreign country) Germany (Swiss Parents)		12. CITIZEN OF WHAT COUNTRY? U.S. of A.	
13. FATHER'S NAME Jacob Schmid		14. MOTHER'S MAIDEN NAME Bosshard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Paul Schmid of 4978-Keppler Rd. Wash. 22 D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.0 DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Macular Degeneration - both eyes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from April , 19 55 , to Oct. 14 , 19 56 , that I last saw the deceased alive on Oct. 14 , 19 56 , and that death occurred at 8:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walcutt W. Gibson M.D.		ADDRESS (Street, city or town, state) 2412 p Minn. Ave. S.E. Wash. 20 D.C. DATE SIGNED 10:14:56	
PHYSICIAN'S NAME (Type) Walcutt W. Gibson M.D.		2412	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Southland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. L. Lee's Sons Co - Wash. D.C.		24a. REC'D BY REGISTRAR 10-16-56	
ADDRESS		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

CERTIFICATE OF DEATH

DECEASED		PRINCE GEORGE'S	
DATE OF DEATH		OCT 18 1956	
PLACE OF DEATH		HOME	
AGE		60-65	
SEX		MALE	
RACE		WHITE	
BIRTH DATE		JAN 1 1896	
BIRTH PLACE		BALTIMORE, MARYLAND	
MARRIAGE		MARRIED	
SPOUSE		JANE JACOB	
OCCUPATION		IRON WORKS	
EDUCATION		HIGH SCHOOL	
RELIGION		METHODIST	
CAUSE OF DEATH		ARTERIO-SCLEROTIC HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE		J. A. JACOB	
WITNESSES		J. A. JACOB, J. A. JACOB	
REGISTRATION		J. A. JACOB	
FILING		J. A. JACOB	
INDEXING		J. A. JACOB	
STAMP		J. A. JACOB	
REMARKS		J. A. JACOB	

BUREAU A. S.

OCT 18 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10586 CERTIFICATE OF DEATH

10614

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b <u>34</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood, Md.</u> d. STREET ADDRESS <u>3703 Webster St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Shelton S. Scruggs</u> First Middle Last			4. DATE OF DEATH <u>Oct 3 1956</u> Month Day Year				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-83</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and kind of business or industry) <u>Engineer for Co. Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S. C.</u>		11. BIRTHPLACE (State or foreign country) <u>S. C.</u>			
13. FATHER'S NAME <u>Allen Benjamin Scruggs</u>			14. MOTHER'S MAIDEN NAME <u>Mary Barnett Scruggs</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1. 212-09-5444</u>		16. SOCIAL SECURITY NO. <u>212-09-5444</u>		17. INFORMANT Address <u>Stella F. Scruggs above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 45 min.</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/3/56</u> , 19____, to <u>10/3/56</u> , 19____, that I last saw the deceased alive on <u>10/3/56</u> , 19____, and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon R. Levitsky</u> M.D. <u>4300 K. Wood Dr., Mt Rainier, Md.</u>			DATE SIGNED <u>10/3/56</u>				
PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Berryville, Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Galler's Funeral Home Inc.</u>		ADDRESS <u>Mt Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 9 56</u> DATE			
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10626 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges'</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croom</u> c. LENGTH OF STAY IN 1b <u>16 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Croom Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges'</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croom</u> d. STREET ADDRESS <u>Croom Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Wainwright Showell</u> First Middle Last				4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1956.</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 19, 1914</u>		9. AGE (In years last birthday) <u>42 yrs.</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Nurses Aide Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Letcher Showell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Virginia Craft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs. John Letcher Showell - Croom, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>gun shot wound of chest</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot self through chest with a revolver</u>							
20c. TIME OF INJURY Month, Day, Year <u>10-28-56</u> Hour, min. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Croome P. O. Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				DATE SIGNED <u>10/29/56</u>			
EXAMINER'S NAME (Type) <u>James I. Boyd, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Newport Cemetery -</u>		22d. LOCATION (City, town, or county) (State) <u>Charles County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Brothers</u>				ADDRESS <u>Upper Marlboro, Md.</u>			
24a. REC'D BY REGISTRAR <u>DATE 2 1956</u>				24b. REGISTRAR'S SIGNATURE <u>H. H. Redwich</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. S.

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10616

10587

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>320 Talbott Ave</u>		d. STREET ADDRESS <u>320 Talbott Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Thomas Smitson</u>		4. DATE OF DEATH <u>October 19 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Smitson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Beckett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-10-4703</u>	
17. INFORMANT <u>Richard Smitson, Laurel, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 18, 1956</u> to <u>October 18, 1956</u> that I last saw the deceased alive on <u>October 18, 1956</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Oct 20, 1956</u>	
ACTUAL SIGNATURE <u>Robert C Wingfield</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ROBERT C WINGFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Anne's, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson</u> ADDRESS <u>Laurel, Md.</u>		24. REC'D BY REGISTRAR <u>WM. B. Haskins</u> DATE <u>Oct 23, 56</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Oct 25 1956</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED
OCT 25 1956
BUREAU V. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10588
CERTIFICATE OF DEATH

10617

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITOL HEIGHTS</u>		c. LENGTH OF STAY IN 1b <u>50 YEARS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>814-57TH AVENUE</u>		d. STREET ADDRESS <u>814-57TH AVENUE</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>B. LIZZIE</u> Last <u>SWEENEY</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 5, 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SCHYLAR</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WILLIAM O. SWEENEY</u>		Address <u>814-57TH AVE CAPITOL HGT. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension essential</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1948, to <u>October 25</u> , 1956, that I last saw the deceased alive on <u>October 25</u> , 1956, and that death occurred at <u>12:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest E. Corvelsen</u>		M.D. <u>4400 B. Road Pl. 25</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST E. CORVELSEN</u>		<u>WASHINGTON 19, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-29-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Bladensburg Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		ADDRESS <u>517-11th St SE</u>	
24a. REC'D BY REGISTRAR <u>Oct. 28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

10528

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1. NAME OF DECEASED JAMES W. WILSON		2. SEX Male		3. AGE 65	
4. DATE OF DEATH October 31, 1956		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. MEDICAL HISTORY Hypertension, Atherosclerosis	
10. SIGNATURE OF PHYSICIAN J. W. Smith, M.D.		11. SIGNATURE OF REGISTRAR A. B. Jones		12. SIGNATURE OF DECEASED None	
13. SIGNATURE OF WITNESSES None		14. SIGNATURE OF FUNERAL HOME None		15. SIGNATURE OF BURIAL PLACE None	
16. SIGNATURE OF COUNTY CLERK None		17. SIGNATURE OF STATE CLERK None		18. SIGNATURE OF DEPARTMENT CLERK None	

BUREAU V. 2

OCT 31 1956

RECEIVED

#1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10627

CERTIFICATE OF DEATH

10618

Reg. Dist. No. 244

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1401st USAF Hospital, Andrews AFB</u>		d. STREET ADDRESS <u>5006 Crawford St., S.E.</u> <u>Wash 21, D.C.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lois Elizabeth Sweeney</u>		4. DATE OF DEATH Month Day Year <u>October 13 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 October 1914</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Village, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. M. Rock</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Woolard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Pauline Lawson, Callao, Virginia</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic carcinoma of cervix to lungs, epidermoid type, with pulmonary effusion, bilaterally</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of cervix, epidermoid type</u> INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Several</u> <u>Months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>0800, 13 Oct, 1956</u> , to <u>1828, 13 Oct 1956</u> , that I last saw the deceased alive on <u>1645, 13 Oct 56 1956</u> , and that death occurred at <u>1828 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm M. Hammon</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1401st USAF Hospital (MATS) 13 Oct 56</u> <u>Andrews Air Forde Base</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM M. HAMMON, Capt, USAF(MC)</u>		<u>Washington 25, D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Church</u>	22d. LOCATION (City, town, or county) (State) <u>Kilmoursack, Va:</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Jr.</u>		ADDRESS <u>317 Pa Ave, S.E.</u>	
24a. REC'D BY REGISTRAR <u>DATE 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Helen Michalek</u>	

BUREAU V.

9561 9 1 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
10619
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ardmore-Ardwick Road				d. STREET ADDRESS Ardmore-Ardwick Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle Watson Last Talley				4. DATE OF DEATH Month October Day 19 Year 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882 Sept. 22, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian (retired)		10b. KIND OF BUSINESS OR INDUSTRY Library		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul P. Watson				14. MOTHER'S MAIDEN NAME Nancy Julia Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Sister Pauline Watson Rayford, Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 490x DUE TO Conditions, if any, which gave rise to immediate cause (b) Lobar pneumonia (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 19, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 10-24-56		22c. NAME OF CEMETERY OR CREMATORY Lee's		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire				24. REC'D BY REGISTRAR 10/23/56 DATE 24b. REGISTRAR'S SIGNATURE H. H. Hedrich			

RECEIVED

OCT 23 1956

BUREAU V. 3

Reverend Father, St. John's
Church, New York, N.Y.
Dear Father:

Enclosed for you are

two copies of the

report of the

Commission on

the

Commission on

the

Commission on

the

Commission on

Commission on

Commission on

Commission on

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10629

CERTIFICATE OF DEATH

10620

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSPITAL				d. STREET ADDRESS 2634 NICHOLS AVE. S.E.			
3. NAME OF DECEASED (Type or print) First Middle Last FRIEDERICK A. TAYLOR				4. DATE OF DEATH Month Day Year 10 28 19 56			
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/09	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER				10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
13. FATHER'S NAME LEWIS TAYLOR				14. MOTHER'S MAIDEN NAME MAGGIE CHANDLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 131-05-6513		17. INFORMANT DECEASED	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNDIFFERENTIATED CARCINOMA 163X - DUE TO: INVOLVING CHEST WALL OR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RIGHT LUNG WITH METASTASIS - DUE TO: TORIBS AND BRAIN (c) TORIBS AND BRAIN							INTERVAL BETWEEN ONSET AND DEATH 1 MO.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10/10 , 19 56 , to 10/28 , 19 56 , that I lost the deceased olive on 10/28 , 19 56 , and that death occurred at 1:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10/28/56 DATE SIGNED							
ACTUAL SIGNATURE Daniel Leo Finucane M.D.				ADDRESS (Street, city or town, state) GLENN DALE HOSPITAL			
PHYSICIAN'S NAME (Type) DANIEL LEO FINUCANE				ADDRESS GLENN DALE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/28/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Mason Funeral Home				ADDRESS 2500 Nichols Ave S.E.		24a. REC'D BY REGISTRAR DATE 10/28/56	
				24b. REGISTRAR'S SIGNATURE Wesley			

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED JAMES E. HUGHES		2. SEX Male		3. AGE 68	
4. DATE OF DEATH October 31, 1955		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Coronary artery disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. DATE OF BIRTH October 1, 1887		11. PLACE OF BIRTH Baltimore, Md.		12. OCCUPATION Retired	
13. MARITAL STATUS Married		14. EDUCATION High School		15. RELIGION Roman Catholic	
16. PREVIOUS ILLNESS Hypertension		17. PRESENT ILLNESS Myocardial infarction		18. MEDICAL HISTORY Hypertension, Diabetes	
19. PHYSICIAN'S SIGNATURE [Signature]		20. COUNTY HEALTH OFFICER'S SIGNATURE [Signature]		21. COUNTY HEALTH OFFICER'S NAME [Name]	
22. COUNTY HEALTH OFFICER'S TITLE Health Officer		23. COUNTY HEALTH OFFICER'S ADDRESS [Address]		24. COUNTY HEALTH OFFICER'S PHONE [Phone]	
25. COUNTY HEALTH OFFICER'S MAILING ADDRESS [Address]		26. COUNTY HEALTH OFFICER'S MAILING PHONE [Phone]		27. COUNTY HEALTH OFFICER'S MAILING CITY Baltimore, Md.	
28. COUNTY HEALTH OFFICER'S MAILING STATE Md.		29. COUNTY HEALTH OFFICER'S MAILING ZIP 21201		30. COUNTY HEALTH OFFICER'S MAILING COUNTRY U.S.A.	

BUREAU V. S.

OCT 31 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10590

Item 6 Film G205 10-22-56 et

CERTIFICATE OF DEATH

10622

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Brown George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>PS</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Piscataway</u>			
3. NAME OF DECEASED (Type or print) <u>Milton</u> First Middle Initial <u>Tayman</u>				4. DATE OF DEATH <u>10-10</u> Month Day Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>George Tayman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Edith Windsor Rt. 2 Brandywine, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Polate</u> 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:10</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederick E. Munner</u> M.D.				ADDRESS (Street, city or town, state) <u>2409 Varnum St. Landover Hills Md.</u>			
DATE SIGNED <u>10/11/56</u>							
PHYSICIAN'S NAME (Type) <u>Frederick E. Munner</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Piscataway, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Southland Home</u> ADDRESS <u>Waldorf Md.</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>161956</u>	

10589

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hackland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>8015 Rhode Island Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Tolson</u> Middle <u>Tolson</u> Last <u>Tolson</u>		4. DATE OF DEATH		Month <u>10</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cal.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-56</u>		9. AGE (In years last birthday) yrs. <u>15</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-SA</u>	
13. FATHER'S NAME <u>Calvin Green</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Elizabeth Tolson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 23, 1956</u> to <u>OCT 23, 1956</u> , that I last saw the deceased alive on <u>OCT 23, 1956</u> , and that death occurred at <u>10:42</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Houmann</u> M.D.				ADDRESS (Street, city or town, state) <u>4404 QUEENSBURY RIVERDALE</u>			
PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/25/56</u>		<u>Methodist</u>		<u>Bladensburg, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francesa Sore Kyster</u> ADDRESS <u>2076 28th St</u>				24a. REC'D BY REGISTRAR DATE <u>10/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>Jas. Seary</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DECEASED'S NAME [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		DATE OF BIRTH [Faint handwritten date]	
PLACE OF BIRTH [Faint handwritten place]		CITY OF DEATH [Faint handwritten city]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]	
MANNER OF DEATH [Faint handwritten manner]		MEDICAL HISTORY [Faint handwritten medical history]	
SOCIAL SECURITY NO. [Faint handwritten number]		MARITAL STATUS [Faint handwritten status]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]	
PLACE OF DEATH [Faint handwritten place]		NAME OF PHYSICIAN [Faint handwritten name]	
NAME OF FUNERAL HOME [Faint handwritten name]		NAME OF BURIAL PLACE [Faint handwritten name]	
SIGNATURE OF DECEASED'S NEXT OF KIN [Faint handwritten signature]		SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF REGISTRAR [Faint handwritten signature]		OFFICIAL USE [Faint handwritten notes]	

BUREAU V. 3

OCT 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10591 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oliver Middle George Last Thomas				4. DATE OF DEATH Month October Day 4 Year 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/89	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Alex Thomas				14. MOTHER'S MAIDEN NAME Olivia Gross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> W.W. I				16. SOCIAL SECURITY NO.			
17. INFORMANT Edith Hailstock				59 Fenton St. N.E. Washington D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compression of the spinal cord 902.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the sixth cervicle vertebrae with dislocation of the sixth and seventh cervicle vertebrae (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 1B.) Fell from an apple tree			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 9/29/ 1956				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/9/56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Ceme.	
22d. LOCATION (City, town, or county) Arlington, Virginia				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Howard				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR DATE OCT 9 '56	
				24b. REGISTRAR'S SIGNATURE Overman			

MEDICAL CERTIFICATION

2

16

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

STATE OF MARYLAND
DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU A.

OCT 9 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10630 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Village-Landover			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		
c. LENGTH OF STAY IN 1b Transient			d. STREET ADDRESS 7609 Kilmer Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Office of Dr. T. Hutchins			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Arthur Middle Robert Last Tippitt			4. DATE OF DEATH Month October Day 20 , Year 1956		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-40	9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolboy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph arthur Tippitt		
14. MOTHER'S MAIDEN NAME Bessie Agnes Cook			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		
16. SOCIAL SECURITY NO.			17. INFORMANT Father- Same address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 919.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of chest DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot accidentally by a shotgun held by another boy.			
20c. TIME OF INJURY Month, Day, Year 3.00 10-19 1956 Hour 3.00 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods	20f. (City or town) Landover	(County) Pr. Geo.	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-20-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/23/56	22c. NAME OF CEMETERY OR CREMATORY Washington National	22d. LOCATION (City, town, or county) (State) Suitland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.		
24a. REC'D BY REGISTRAR DATE			24b. REGISTRAR'S SIGNATURE D. H. Hutchins		

OCT 23 1956

RECEIVED

OCT 28 1956

BUREAU V. S.

Shot accidentally by a shot in held by another boy.

Landover

Woods

20

10-10

XX

Gunshot wound of chest

Hemorrhage and shock

Father - same address

Basile Arnes Cook

Hammond

15

10-11-10

Tipitt

Labover

Robert

John

Office of Dr. T. H. H. H.

West Village - Landover, Maryland

Prince George

Landover

11, 1950

10545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Prince George

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)

a. STATE

md.

b. COUNTY

Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HYATTSVILLE

c. LENGTH OF STAY IN 1b

1 week

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Colman Manor

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

PAINT BRANCH Nursing Home

d. STREET ADDRESS

4304 Monroe St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Nelson

John

Tubbs

4. DATE OF DEATH

Month

Day

Year

October 22 1956

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Aug. 15, 1871

9. AGE (In years last birthday)

85 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

ENGINEER

11. BIRTHPLACE (State or foreign country)

MICHIGAN

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ELIHU TUBBS

14. MOTHER'S MAIDEN NAME

MILLIE QUICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

MRS. NELLIE TUBBS

Address COLMAN MANOR

4304-7 Monroe St MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Broncho pneumonia

INTERVAL BETWEEN ONSET AND DEATH

48 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Cerebral Arteriosclerosis

5 years

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. n. p. m.20d. INJURY OCCURRED While ☐ Nat while ☐ at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 1953, to OCT 22 1956, that I last saw the deceased alive on OCT 22 1956, and that death occurred at 11:03 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE

Norman Donat Comeau

M.D.

ADDRESS (Street, city or town, state)

3503 Penny St

DATE SIGNED

OCT 22, 1956

PHYSICIAN'S NAME (Type)

Norman Donat Comeau

MT RAINIER MD.

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL OCT 26, 1956

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

Cedar Hill

22d. LOCATION (City, town, or county)

Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE

J. Gaffell

ADDRESS

475-H St N. N. York

24a. REC'D BY REGISTRAR

DATE OCT 28 1956

24b. REGISTRAR'S SIGNATURE

James Leary

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 OCT 29

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10626

10547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montgomery Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>16 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u>		<u>15x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>93 Mrs Bell's Home 6403 Ager Road</u>				d. STREET ADDRESS <u>3502 - Everton St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Deborah</u> Last <u>Wilks</u>				4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>May 23, 1955</u>		9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E Wilks</u>				14. MOTHER'S MAIDEN NAME <u>Jane Mc Neely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>History in Nursing Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus (extreme)</u> <u>751X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spina Bifida</u> DUE TO (c) <u>Terminal destruction of vital brain centers</u>						INTERVAL BETWEEN ONSET AND DEATH <u>birth on</u> <u>birth on</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 2</u> , 19 <u>55</u> , to <u>Oct 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.				ADDRESS (Street, city or town, state) <u>College Park, Md</u>		DATE SIGNED <u>10/3/56</u>	
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>				<u>6905 Baltimore Blvd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 8 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Jones</u>			

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is partially filled with handwritten text.

BUREAU V. S.

OCT 8 1956

RECEIVED

Continuation of the death certificate form, including fields for medical history, autopsy, and certification. The form is partially filled with handwritten text.

10548

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>	
c. LENGTH OF STAY IN 1b <u>25 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4216 Ogletrope St</u>		d. STREET ADDRESS <u>4216 Ogletrope St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARK</u> First <u>WILKES</u> Middle <u>WILLIAMS</u> Last		4. DATE OF DEATH Month <u>Oct</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9,</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ernest Williams</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Garrett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Louis C Williams - Hyattsville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cecum</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>48</u> , to <u>10-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-5</u> , 19 <u>56</u> , and that death occurred at <u>6:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Deitz</u> M.D.		ADDRESS (Street, city or town, state) <u>Hyattsville, Md</u>	
DATE SIGNED <u>10-6-56</u>			
PHYSICIAN'S NAME (Type) <u>A. Deitz M.D.</u>		<u>Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>	22b. DATE THEREOF <u>10/7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Charlotte</u>	22d. LOCATION (City, town, or county) (State) <u>North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11 1956</u>		24b. REGISTRAR'S SIGNATURE <u>James Seacys</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 11 OCT

BUREAU A.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10592

CERTIFICATE OF DEATH

10629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>B</u> Last <u>Winant</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3 1892</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>4</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>agronomist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>University of Md</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Winant</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Lemon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records Chesley Md.</u>		Address <u>Chesley Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>40 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 19, 55</u> to <u>October 4, 1956</u> , that I last saw the deceased alive on <u>October 4, 1956</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lion L. Gallin</u>		ADDRESS (Street, city or town, state) <u>7206 Columbia Rd.</u>	
PHYSICIAN'S NAME (Type) <u>University Hills Md</u>		DATE SIGNED <u>10/4/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/6/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincolns</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gascha Sons Hyattsville Md</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10631 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince George's</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Prince George's</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	LENGTH OF STAY (in this place) <i>5 years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	
TOWN <i>Forest Heights</i>		TOWN <i>Forest Heights</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<i>338- Huron Drive</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>ANDREW THOMAS YOUNG</i>		OF DEATH: <i>10 - 10 19 56</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>April 23, 1900</i>
9. AGE last birthday <i>56</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Guard</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>U.S. Government</i>	
11. BIRTHPLACE (State or foreign country): <i>Michigan</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>William Young</i>		14. MOTHER'S M maiden NAME: <i>Rose Marie Heinsheim</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk. (If Yes, give war or dates of service)) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>367-16-6421</i>	
17. INFORMANT & ADDRESS: <i>Andis L. Young 338- Huron Dr. Forest Hts. Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Peripheral Vascular Collapse</i>			<i>3 days</i>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Carcinoma of Spleen</i>			<i>10 mo</i>
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>Feb 1956</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Inoperable Carcinoma of Spleen</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <i>January, 1956</i> to <i>Oct 10, 1956</i> that I last saw the deceased alive on <i>Oct 10, 1956</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>John J. Gaedy</i>		ADDRESS <i>M.D. 284 Nichols Ave SE, Wash D.C.</i>	
DATE SIGNED <i>10-10-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10-13-56</i>	
NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>		LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
DATE RECD BY LOCAL REGISTRAR <i>Oct 11-56</i>		REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>	
24. FUNERAL DIRECTOR <i>W.W. Chambers</i>		ADDRESS <i>6. 577-11 St. N.E.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 16 1956
BUREAU V. B.